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| **Records Release Form**  **(Authorization to RELEASE Protected Health Information)** |

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| **PATIENT INFORMATION**   |  | | --- | | **First Name Last Name MI** | | **Date of Birth Social Security Number** | | **Street Address City State Zip Code** | | **Home Phone Number Cell Phone Number Work Phone Number**  **( ) - \_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_** |   **I authorize Berkeley Family Practice, LLC to RELEASE my medical records TO:**   |  | | --- | | **Name of Business / Person(s) / Entity** | | **Street Address City State Zip Code** | | **Phone Number Fax Number**  **( ) - \_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_** | | **Please check one of the following: ○ Mail My Records to Business/Person(s)/Entity Above ○ I Will Pick Up My Records**  **Information for Treatment Period:**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(Date)**                                            **(Date)** |   **I authorize the release of the following Personal Health Information including but not limited to:**   * Patient Identification / Diagnosis List ● Radiology Films & Reports * EKG / Cardiovascular ● Physical Therapy Notes * Pathology Reports & Lab Tests ● Billing Information * Pulmonary Function Tests ● Occupational Therapy * Office Notes / Physical Dictation   **Please initial beside each item:**  \_\_\_\_\_ SENSITIVE INFORMATION: I understand that my record may include information relating to acquired immune-deficiency syndrome (AIDS) or Human Immuno-Deficiency Infection, Psychological Assessment, Behavioral and/or Mental Health Services, Sexually Transmitted Diseases, Alcohol and/or Drug Abuse and this information will be released.  \_\_\_\_\_ RE-DISCLOSURE:  I understand that any disclosure of information carries with the potential for re-disclosure and the information then may not be protected by federal confidentiality rules.  \_\_\_\_\_ RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.  \_\_\_\_\_ EXPIRATION: : I understand that this authorization will expire 12 months after signed unless an earlier date is advised here.  \_\_\_\_\_ CHARGES: I understand that there may be a charge for releasing the requested information.  RecordQuest has been contacted to provide the service and will bill you directly.  Questions may be directed to RecordQuest @ 888.300.7410.  **I HAVE READ THE ABOVE STATEMENTS AND POLICIES OF BERKELEY FAMILY PRACTICE, LLC AND BY SIGNING BELOW, ACKNOWLEDGE RECEIPT AND UNDERSTANDING OF THE SAME.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Patient or Legal Representative **Date**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Description of Legal Representative’s Authority (attach necessary documents |