BERKELEY FAMILY PRACTICE, LLC

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Records Release Form
(Authorization to RELEASE Protected Health Information)

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
- EKG / Cardiovascular
- Pathology Reports & Lab Tests
- Pulmonary Function Tests
- Office Notes / Physical Dictation
- Radiology Films & Reports
- Physical Therapy Notes
- Billing Information
- Occupational Therapy

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**

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Description of Legal Representative's Authority (attach necessary documents