

Physicians of Family Medicine
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name)

Birth date (Mo/Day/Yr)

(Street address)

Social security number

(City, state, zip code)

Phone (Home)

At the request of the individual, I _____, do hereby authorize _____ to release:
(Patients Name) (Name of Facility)

DATES OF _____

_____ DISCHARGE SUMMARY

_____ PATHOLOGY REPORTS

_____ EMERGENCY REPORTS

_____ HISTORY & PHYSICAL

_____ LABORATORY REPORTS

_____ OTHER _____

_____ PROGRESS NOTES

_____ RADIOLOGY REPORTS

_____ OPERATIVE NOTES

_____ ECG/EEG/CARDIC CATH

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

Name of Company/Agency/Facility/Person

Street address

City, state, zip

PURPOSE OF DISCLOSURE:

_____ REFERRAL TO SPECIALIST

_____ INSURANCE

_____ WORKERS COMP

_____ CHANGE OF DOCTOR

_____ LEGAL INVESTIGATION

_____ DISABILITY DETERMINATION

_____ PERSONAL

_____ CONTINUING CARE

OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

**Signature of individual or guardian or
Personal Representative of patient's estate**

Date

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. HealthPort has been contracted to provide this service and will invoice you directly.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE _____

LAB _____

EKG _____

DS _____

EKG _____

IMMUNE _____

OP _____

X-Ray _____

OTHER _____

HP _____

PATH _____

NUMBER OF PAGES _____

ROI SPECIALIST

DATE

Physicians of Family Medicine
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CHANGE OF DOCTOR INFORMATION

PLEASE READ THE FOLLOWING INFORMATION

TERMS AND CONDITIONS FOR TRANSFER

I AM TRANSFERRING TO ANOTHER PRIMARY CARE PHYSICIAN (PCP) DUE TO THE FOLLOWING REASONS:

PLEASE CHECK ONE

- CHANGING HEALTHCARE INSURANCE AND PHYSICIANS OF FAMILY MEDICINE PROVIDERS ARE OUT OF NETWORK
- MOVING OUT OF THE AREA
- DUE TO PERSONAL REASONS CONCERNING MY PROVIDER OR THE STAFF

I UNDERSTAND THAT IF I AM TRANSFERRING TO ANOTHER PCP DUE TO PERSONAL REASONS CONCERNING MY PROVIDER OR THE STAFF, THEN I WILL NO LONGER BE CONSIDERED A PATIENT AT PHYSICIANS OF FAMILY MEDICINE AFTER THE DATE INDICATED BELOW. UPON WRITTEN AUTHORIZATION, WE WILL PROVIDE COPIES OF YOUR MEDICAL RECORDS TO YOUR NEW PCP. THERE WILL BE A CHARGE TO YOU FOR THIS SERVICE.

I have read the above and authorize the disclosure of the Terms and Conditions for Transfer.

Signature of Patient/Guardian/Patient Representative:	Date:
Signature of Manager/Witness:	Date: