

"Bringing Old-Fashioned Medicine Back Home"

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Request to Release, Copy, or Inspect Protected Health Information

Patient Name: _____

Date of Birth: _____

Patient Address: _____

Phone #: _____

Street

City, State Zip

For Record Release or Copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me / my child.

This authorization permits:

_____	to use or disclose to	_____
Provider's Name		New Provider, Specialist, or Person Receiving Copy
_____		_____
Street Address		Street Address
_____		_____
City, State ZIP		City, State ZIP
_____		_____
Phone #		Phone #

Information to be Released/Copied: () All pertinent medical records including immunizations and lab tests

() Encounter Notes – *dates:* _____ () Lab Info –*dates:* _____
() Other: _____

Information to be Excluded/ Not Released: () None () Mental Health Records
() Drug/ Alcohol Treatment () HIV Testing () Sexual Assault/Victimization Records
() Other: _____

Reason for Record Release or Copy: () Personal Copy <see below / charges apply
() Over age 21 () Insurance Change () Moving/ Changing Providers () Referral to Specialist
() Unhappy with Practice (Please state why) _____
() Other : _____

For Patient or Guardian Inspection/Copy Requests: () Check Here

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including, the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: **\$.50 per page for the first 25 pages, then \$.30 for each page thereafter.**

Signature of Patient or Legal Guardian

Date

Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY: Name and Title of Person Releasing Records _____	
Method of Transfer: Mailed on (date) _____	Certified? (certification #) _____
Faxed to (number) _____	on (date) _____
Emailed to (name & email) _____	on (date) _____

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