Family Medicine, PC

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Patient Authorization to Release Protected Health Information

Patient Name: ______________________________ DOB: ________________

Address: ______________________________ Phone# ________________

The following individual or organization is authorized to release protected health information on the above-named patient: **(Where the records are coming from)**

Name or Organization ______________________

Address ______________________

Phone ______________________

The protected health information may be released to and used by the following individual or organization:

(Where the records are going)

Name or Organization ______________________

Address ______________________

Phone ____________ Fax ____________

Email *(optional)*: ______________________

Please read "Patient Statement" regarding email transmission

A. The protected health information to be released includes:

❑ Complete Medical Record (last 7 years)
❑ Radiology results from __________ to __________
❑ Medical record from __________ to __________
❑ Lab results from __________ to __________
❑ Office notes only from __________ to __________
❑ Other ______________________

B. The protected health information to be release will be used for:

❑Personal Use: *We reserve the right to charge patients for medical records under 45CFR 164.524(c)(4). For paper copies $30.00 for the first 15 pgs. and $0.25/pg after; $7.00 for emailed; $17.00 for thumb drive.*

Total # of pgs.________ Format ________Total $________ Method of payment ______________

❑ Transfer of primary care ❑ Specialist visit ❑ Insurance ❑ Other ______________________

C. Patient Statement: *Please read in its entirety and ask any questions prior to signing*

I certify I have read this voluntary authorization. I hereby release Family Medicine, PC, its employees, agents, and medical providers who provide health information for all liability and claims of any nature that may arise from the release of information contained in the medical record. I understand that the revocation will not apply to any information already released based on this authorization. I understand this information may be disclosed again by the recipient and thus will no longer be protected by privacy regulations. I understand if I request to have records emailed, information is not encrypted, and a third party may be able to access and view my protected health information; furthermore, by signing below, I accept the associated risks with receiving and sending protected health information via email and release Family Medicine, PC, its employees, agents, and medical providers who provide health information via email, for all liability and claims of any nature that may arise from the release of information contained in the medical record. This form was filled out before I signed it and I acknowledge that all my questions were answered to my satisfaction. This authorization is valid the date I have signed below and shall remain valid for a period of one year.

______________________________ ______________________ *revised 2024*

Signature of patient, guardian, or legal representative Date