I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient name), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date of birth), hereby authorize the use or disclosure of medical records to:

**Superstition Family Medicine**

FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PHYSICIAN/GROUP NAME)

-or-

 TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PHYSICIAN/GROUP NAME)

 FROM **Superstition Family Medicine**

FOR TRANSFER OF CARE / CONTINUITY OF CARE (CIRCLE ONE)

 I authorize the following information to be disclosed:

 \_\_\_\_\_ COMPLETE MEDICAL RECORD

 \_\_\_\_\_ PROGRESS NOTES

 \_\_\_\_\_ LABS/PATHOLOGY REPORTS

 \_\_\_\_\_IMAGING REPORTS ONLY

 OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I UNDERSTAND THE INFORMATION IN MY RECORDS MAY CONTAIN INFORMATION RELATED TO HIV/AIDS,

COMMUNICABLE DISEASES, MENTAL HEALTH, DRUG/ALCOHOL ABUSE. I UNDERSTAND THAT I MAY REVOKE THIS

AUTHORIZATION AT ANYTIME. I UNDERSTAND THAT THIS IS VOLUNTARY AND I DO NOT NEED TO SIGN THIS FOR

MEDICAL TREATMENT. A COPY OF THIS IS VALID AS AN ORIGINAL AND WILL EXPIRE 1 YEAR FROM THE DATE BELOW.

 DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PATIENT/RESPONSIBLE PARTY SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WITNESS INITIALS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Records Release Form**

**Superstition Family Medicine**

**Make Primary Care Great Again!**



