Please note that there may be a charge for providing copies of your medical records as allowed by Federal & State Law

Medical Records of (Patient Information):

First:_____ Date of Birth:_____

Maiden/Middle:_____

Last:_____ Last 4 digits of SS #:_____

Address: Street Name:_____

City:_____ State_____ Zip Code_____

Telephone:_____ Email:_____

Practice Name:_____

Address:_____

_____

_____ OR

Fax To: _____

Telephone:_____

RECORDS TO BE RELEASED FROM:

Practice or physician name & address: _____

RECORDS TO BE RELEASED TO: I, _____ request and authorize CFMG to release my medical & billings records as indicated below to:

Name of person or organization receiving records: _____

Address: _____

Fax:_____ Telephone:_____ Email:_____

FORMAT & METHOD OF DELIVERY: CFMG *will provide paper copies of the requested records. You may request an alternative delivery format, and if we are able, we will provide the records in the requested format:* _____

REASON FOR DISCLOSURE (*For the purpose of):*

☐ Continuing Care	☐ Referral to a Specialist	☐ Change of Doctor/Provider	☐ Personal
☐ Insurance	☐ Workers Comp	☐ Disability Determination	☐ Legal

INFORMATION TO BE RELEASED: At my request, I authorize disclosure of my health information as indicated below (*check all that those that apply*):

☐ **Date(s) of service:** From_____ to _____ OR, ☐ Last two years

☐ provider notes	☐ X-ray reports
☐ Special Diagnostic test results	☐ Chemical/Alcohol Treatment records
☐ Lab reports	☐ Medical & Billing Records:
☐ Billing records	☐ Other (specify)

I UNDERSTAND: (1) THAT THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE; (2) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY CALLING Care First Medical Group **AT** 470-250-098 **HOWEVER, THE REVOCATION WILL NOT HAVE AN EFFECT ON ANY ACTIONS TAKEN PRIOR TO THE DATE MY REVOCATION IS RECEIVED AND PROCESSED BY** CFMG**. (3) MY HEALTH INFORMATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE AUTHORIZED RECIPIENT, AND IF THE RECIPIENT IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE INFORMATION MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT** CFMG **WOULD NOT BE RESPONSIBLE FOR THIS ACTION; (4) I AM ENTITLED TO ASK FOR AND RECEIVE A COPY OF THIS DOCUMENT, AND; (5) I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE HEALTH CARE TREATMENT AND** CFMG **WILL NOT CONDITION TREATMENT, PAYMENT, ON WHETHER I SIGN THIS AUTHORIZATION.** ***Specify authorization expiration date (if not 60 days)*** _____

Patient Signature: _____ Date_____

Patient Legal Representative: _____ _____ _____ _____

(Name) *(Relationship to patient)* *(Signature)* *Date)*

For Office Use

Date Received: _____ Received by: _____

Date Released: _____ Released by: _____