Patient Request for Medical Records Transfer
Authorization for Release of Protected Health Information

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PATIENT INFORMATION

Patient Name		Date of Birth	
Street Address	City	State	ZIP Code

I have been a patient of your office/facility (or am the patient's authorized representative) and I understand that the practice/facility provider has legally protected health information about me (or the person I represent) that I wish to transfer.

PROVIDER THAT HAS YOUR RECORDS

I, _____ hereby authorize the provider to release my records:

Provider Name			
Street Address	City	State	ZIP Code
Phone Number	Fax Number		

PROVIDER YOU WANT TO RECEIVE YOUR RECORDS

Provider Name			
Street Address	City	State	ZIP Code
Phone Number	Fax Number		

Medical records to be released: (please check all that apply)

- ☐ Entire Medical Record*
- ☐ Assessment/history and physical
- ☐ Emergency Department
- ☐ Operative Reports
- ☐ Lab Results
- ☐ Discharge Summary
- ☐ Radiology (X-ray, CT, MRI, etc.)
- ☐ Outpatient/Clinic (specify): _____
- ☐ Other (specify): _____

For treatment dates from _____ to _____

* I understand that the protected health information (PHI) I am requesting may include disclosure of information regarding HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, genetic information/testing or mental illness. I authorize the release or disclosure of this information.

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- By signing below, I acknowledge that: I may revoke this authorization in writing, but it will not affect disclosures/ transfers already in progress made with this authorization.
- I may refuse to sign this authorization, and my treatment may not be conditioned on my signing of this form, unless the purpose of my treatment is disclosure to a third party (for example, a drug test for employment).
- I can receive a copy of this authorization upon request.
- A photocopy or scanned image of this authorization may be used in lieu of the original.
- I understand that recipients may not be subject to federal law and disclose information which I have authorized them to receive.

Signature: _____ Date: _____

If signed by a personal representative of patient, print name and relationship to patient:

Name: _____ Relationship: _____

Please attach a copy of documentation of personal representation *(Power of Attorney, Legal Guardianship)*.