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Medical Records Release Form

I understand when my information is used or disclosed pursuant to this authorization; it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Information Portability and Accountability Act (HIPAA) Privacy Rule. I do not have to sign this authorization in order to receive treatment from this practice. In fact, I have the right to refuse to sign this authorization unless my treatment is for research purposes or to determine benefits or employment status.

Please Print

I authorize _____

(***Medical Facility*** or ***previous provider*** where we are requesting records)

_____

(Address)

_____

(Telephone) (Fax)

To release the following medical information on behalf of:

_____

(Patient's Name) (Date of Birth)

PLEASE SUBMIT ON DISC OR FLASH DRIVE

Disclose the following requested information from my medical records (if applicable):

- General Medical Records - Last 2 years Only
- Cardiovascular Testing – All
- HIV/AIDS Screening & Results
- Laboratory Studies - Last 2 years Only
- Medication List - Current
- Immunizations - All
- Pathology Records (Including PAPS) - All
- Colonoscopy w/ Pathology - All
- Mammography - Past 2 mammograms & any abnormal results

Purpose of the use and/or disclosure: **TRANSFER OF CARE**

I have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Bayside Family & Sports Medicine. This information may not be used for any other purpose or released to any other person(s) without my written consent. This release is effective for one year from the date of execution.

_____ _____

Signature of Patient or Legal Guardian Date