BERENBEIM
OSTEOPATHIC, P.C.

Medical Record Release Form

By signing this form, I authorize you (Name: _____), to release confidential health information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

__Complete Records __Care Plan __Pathology Reports __Hospital Records __History & Physical __Lab Reports __Treatment Record __Medication Record __Progress Notes __Radiology Reports __Operative Reports __Other_____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____

Address: _____

City: State: Zip Code: _____

The purpose/reason for this release of information is as follows:

___Personal Use ___Continuity of Medical Care ___Legal ___Claim Information ___Other_____

Exclude the following information from the records released (please initial):

___Drug/Alcohol abuse/treatment & diagnosis ___HIV/AIDS diagnosis/treatment/testing

___Sexually transmitted disease ___Mental illness or psychiatric diagnosis/treatment

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed and THAT THERE MAY BE A COST TO COPY THE RECORDS.

I understand that this consent expires 180 days from the date of my signature unless otherwise specified as follows: _____ I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

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