Richard L. Grandjean, M.D., P.A.

Diplomate, American Board of Family Medicine
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Forest Park Family Medicine
12222 N. Central Expressway
Suite 200, Lock Box 12
Dallas, Texas 75243-3759

Raintree Family Medicine
997 Raintree Circle
Suite 180, Lock Box 8
Allen, Texas 75013-4949

MEDICAL RECORDS RELEASE AUTHORIZATION (INCOMING)

ATTENTION OFFICE STAFF:
Please fax all incoming records to ***1 (877) 448-0543***. Include chart number (below) in subject if e-mailing to: ***grandjeanmd@meditouchehr.com***.

Patient Name: ____
Last First MI

Date of Birth: ______________ Last 4 of SSN: ______________ **Chart Number:** ______________

I hereby authorize: ______________________________ ______________________ - Fax
______________________________ ______________________ - Fax
______________________________ ______________________ - Fax

to release the following medical records to:

☐ Raintree Family Medicine | Richard L. Grandjean, M.D., P.A.
997 Raintree Circle, Suite 180, Lock Box 8 | Allen, Texas 75013-4949

☐ Forest Park Family Medicine | Richard L. Grandjean, M.D., P.A.
12222 N. Central Expressway, Suite 200, Lock Box 12 | Dallas, Texas 75243-3759

This authorization applies to the following records:

________ Any and all records;

________ Records pertaining to illness/injury occurring between __________ and __________;

________ Records from __________ to ____________;

________ Specific reports: ____

Hospital Discharge Summary	Operative Summary	Radiology Reports
Emergency Department Visit	Laboratory Reports	Progress Notes
Drug/Alcohol Testing*	Mental Health Notes*	Psychotherapy Notes*

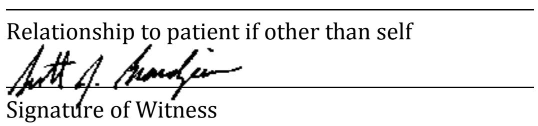
Purpose of request: Coordination of care** Specialist referral** Transfer of Records

I understand the purpose of this release is to clarify and enhance my care and treatment. Further, records may contain reference to or results of HIV antibody (AIDS), drug, alcohol testing and or mental health information, with my consent.

A duplicate or photostatic copy or facsimile reproduction of this authorization may be used in lieu of the original. You are hereby released from all liability arising out of, or in any way incident to, producing records or providing information pursuant to this authorization.

______________________________ ______________
Signature of patient or responsible party Date

____
Relationship to patient if other than self


____
Signature of Witness

* Requests for release of drug/alcohol testing and mental health or psychotherapy notes require written authorization from the patient.
** A signed authorization is not required for coordination of care or specialist referral requests.

This document may contain information covered under the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations, and must be protected in accordance with those provisions. If this correspondence contains protected health information (PHI) it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized disclosure or failure to maintain confidentiality subjects you to application of appropriate civil and criminal penalties. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made.