LAWRENCE FAMILY MEDICINE

MEDICAL RECORDS TRANSFER REQUEST – **INCOMING** (SENT TO OUR OFFICE)

I hereby authorize and request B. Brooks Lawrence, M.D., P.A., to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations. I understand that my Protected Health Information is as follows: *Information that is oral or recorded that relates to my past, present, or future physical or mental health condition; my past, present, or future health care treatment that is or could be reasonable to identify me and is transmitted in an electronic form or maintained in any form.* The Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source and could include demographic information about me.

Please transfer (**CHECK ONE BELOW**):

_____ all records in your possession concerning any diagnosis, prognosis, and recommendations, as well as other data related to your treatment of the patient named below.

OR

_____ specific records noted here: _____

*****PATIENT NAME: _____**
(Please print full name)

*****PATIENT DATE OF BIRTH: _____**

TO: B. Brooks Lawrence, M.D., P.A.; P.O. Box 10581; Conway, AR., 72034

Phone: 501-327-6900 Fax: 888-782-8072

FROM: _____
(name of physician/medical clinic/insurance; recipient)

_____ _____ _____
(city) (state) (zip code)

Sender's telephone: _____ **Sender's Fax # _____**

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information. I request this authorization never expire, unless I request so in writing to Lawrence Family Medicine Clinic.

I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization.

X _____ **DATE: _____**
(patient or guardian signature)