

Appledore Medical Group
Medical Records Release Form

Patient Name:	Birth Date:	Phone:	Last 4 Digit SSN (optional)
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Address:	City/State:	Zip:
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Appledore Medical Group Physician: _____ Phone: _____ Fax: _____	<input type="checkbox"/> Records to be sent to:	<input type="checkbox"/> Records to be received from:	
	Name: _____		
	Street: _____		
	City: _____	State: _____	Zip: _____
	Phone: _____	Fax: _____	

Request Delivery (If left blank, a paper copy will be provided):
 Paper Copy
 Electronic Media, if available (e.g., USB drive, CD/DVD)
 Encrypted Email
 Unencrypted Email

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

This authorization will expire on the following:
Date: _____ **OR**
Event: _____

Purpose of Disclosure:
 Transfer of Care (new PCP)
 Personal Use
 Other: _____

Description of information to be used or disclosed

Is this request for psychotherapy notes?
 Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
 No, then you may check as many items below as you need.

Description	Date(s)	Description	Date(s) & Where	Description	Date(s) & Who or Where
<input type="checkbox"/> All PHI in record		<input type="checkbox"/> Mammogram		<input type="checkbox"/> Laboratory Results	
<input type="checkbox"/> Immunization Record		<input type="checkbox"/> X-Rays		<input type="checkbox"/> Specialist Records	
<input type="checkbox"/> Medication List		<input type="checkbox"/> Ultrasound		<input type="checkbox"/> Hospital Records	
<input type="checkbox"/> Office Notes		<input type="checkbox"/> MRI		<input type="checkbox"/> Itemized Bill	
<input type="checkbox"/> Annual Physical		<input type="checkbox"/> Cat Scan		<input type="checkbox"/> OTHER :	
<input type="checkbox"/> Pap Smear Results		<input type="checkbox"/> Diagnostic Testing			

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here.

- I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
 6. I get a copy of this form after I sign it.

Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete this section, otherwise skip to Signatures

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?
 Yes
 No
If yes, describe: _____

Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	Date:
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Print Name of Patient's Representative:	Relationship to Patient:
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Fee for copying records: When a patient requests to personally obtain copies of medical records, a fee will be charged to the patient. In the event of a transfer of care, Appledore Medical Group will provide copies of the records to their new primary care office at no charge to the patient. Please contact our medical records department for further details.