GOLDEN TRIANGLE

FAMILY CARE CENTER

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HIPAA COMPLIANT REQUEST FOR MEDICAL RECORDS

This document authorizes you to disclose us the following health information concerning the patient, _____, whose date of birth is _____ and whose social security number is _____ for the purpose of continuing medical management of the person's health issues.

TO: _____

Fax#: _____ Phone#: _____

This authorization applies to the following records:

☐ All medical records including, but not limited to, inpatient, outpatient and emergency room treatment, all clinical records, reports, documents, correspondence, test results, statements, questionnaires/histories, office, and doctor's hand written notes, and records received by other physicians. This also includes all CT scans, mammograms, MRI's and other radiological reports that may be available and laboratory results. This also includes any pathology reports available.

☐ Laboratory AND Pathology Reports/Results

☐ Radiology results such as CT scans, MRI's, mammograms, bone scans.

☐ Office progress notes and any handwritten physician notes.

This authorization does not apply to psychiatric, psychotherapy, or psychological notes or records.

I hereby release your facility, physician and employees from liability associated with release of this information. I understand this information has been disclosed to me from records whose confidentiality is protected by Federal Law. I understand that Federal regulations prohibit me from making any further disclosure of this information except with specific written consent of the patient.

By Signing below I further acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by a recipient and not protected under the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

This authorization expires two years from the date signed below.

_____ _____

Signature of Patient Date