Authorization to Release Medical Records

Use this form to authorize Qualls Harbin Family Medicine to send records to another provider, or to request records from a previous provider.

Patient Information

Patient name _____ Date of birth _____

Direction of Release

- ■ Release records FROM Qualls Harbin Family Medicine TO the provider named below
- ■ Request records FROM the provider named below TO Qualls Harbin Family Medicine

Other provider / facility name _____ Phone _____

Address _____ Fax _____

Purpose of Disclosure

- ■ Continuity of care / transfer to a new provider
- ■ Personal records
- ■ Other (describe below)

_____

Records to Release

- ■ Entire chart
- ■ Office visit notes only
- ■ Lab / test results only
- ■ Immunization records only
- ■ Records for date range:

From _____ To _____

Authorization

I authorize Qualls Harbin Family Medicine to disclose the health information described above. Signing this authorization is voluntary — the practice will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign it. I understand that I may revoke this authorization in writing at any time by notifying the practice at the address above, except to the extent action has already been taken in reliance on it, and that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy law. Unless otherwise revoked, this authorization expires one year from the date signed below. I will be given a copy of this signed authorization for my records.

Patient / Guardian signature Date

Relationship to patient (if signed by guardian/representative)