HealthMotivate Care

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Medical Records Release

Patient Name_____Date of Birth_____

Information to be released from:

Facility or Provider_____

Address_____Phone Number (_____)_____

City_____State_____Zip code_____Fax Number (_____)_____

I request and authorize the facility or provider named above to release health care information of the patient named above to:

Name of designated recipient_____

Address_____Phone Number (_____)_____

City_____State_____Zip code_____Fax Number (_____)_____

Information to be released:
☐ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
☐ All medical records
☐ Electronic records
☐ Specific information (Please specify):_____

For the following purpose:_____

The following items must be initialed to be included in the use and/or disclosure of other health information:
_____HIV/AIDS related information and/or records
_____Mental health information and/or records
_____Genetic testing information and/or records
_____Drug/alcohol diagnosis, treatment or referral information (federal regulations require a description of how much and what kind of information is to be disclosed) Describe:_____

Patient Authorization:

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.

_____ _____
Signature of Patient or legal representative Date

_____ _____
Print Patient's Name Print Name of Legal Rep/relationship to patient