MARVIX AI

HIPAA MEDICAL RECORDS RELEASE FORM

Questions? Visit us at **www.marvix.ai**

1 PATIENT INFORMATION

NAME

AGE / SEX

PHONE NUMBER

ADDRESS

PA PURPOSE OF AUTHORIZATION

Continuity of care, personal records, insurance processing, legal request, disability claim, school / work documentation, or transfer of care. HIPAA requires valid written authorization for disclosures not otherwise permitted by the Privacy Rule...

ER ENTITY AUTHORIZED TO RELEASE RECORDS

NAME OF FACILITY / PROVIDER

PHONE

EMAIL / RECORDS DEPARTMENT CONTACT

RR RECIPIENT OF RECORDS

RECIPIENT NAME / ORGANIZATION

PHONE

EMAIL

IR INFORMATION TO BE RELEASED

- [ ] Complete medical record
- [ ] Office visit notes
- [ ] Hospital records
- [ ] Laboratory results
- [ ] Imaging reports
- [ ] Medication history

- [ ] Immunization records
- [ ] Billing records
- [ ] Operative / procedure reports
- [ ] Pathology reports
- [ ] Behavioral health records (if authorized)
- [ ] Substance use disorder records (if separately authorized)
- [ ] HIV/AIDS-related information (if authorized)
- [ ] Genetic testing information (if authorized)

Other:

DR DATE RANGE / PURPOSE / METHOD

6a DATE RANGE

FROM

TO

OR SPECIFY (MOST RECENT / ENTIRE RECORD / SPECIFIC EPISODE)

6b PURPOSE OF DISCLOSURE

Purpose:

6c METHOD OF RELEASE

- [ ] Paper copy
- [ ] Electronic copy
- [ ] Secure email
- [ ] Fax
- [ ] Patient portal
- [ ] CD / USB / electronic media
- [ ] Direct transfer to another provider
- [ ] Pick up by patient / authorized representative

Preferred Delivery Method:

EX EXPIRATION / RIGHT TO REVOKE / REDISCLOSURE

7a EXPIRATION

Expiration Date:

7b RIGHT TO REVOKE

Patient may revoke this authorization in writing at any time, except to the extent that action has already been taken.

Submit written revocation to (Address / Fax / Email):

7c REDISCLOSURE NOTICE

Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA, depending on the recipient and applicable law.

7d FEE NOTICE & PATIENT RIGHTS STATEMENT

Fee Notice:

Signing is voluntary. Treatment generally may not be conditioned on signing. Patient may request a copy of this signed authorization. Patient may revoke in writing as described above.

SG PATIENT / LEGAL REPRESENTATIVE SIGNATURE

PATIENT SIGNATURE

PRINTED NAME

8a IF SIGNED BY LEGAL REPRESENTATIVE

REPRESENTATIVE NAME

RELATIONSHIP / AUTHORITY

PHONE NUMBER

DATE

WS WITNESS / STAFF VERIFICATION

WITNESS / STAFF NAME

SIGNATURE

DATE

TIME

FO FACILITY USE ONLY

REQUEST RECEIVED DATE

IDENTITY VERIFIED

RECORDS RELEASED

METHOD OF RELEASE

NOTES