Physicians of Family Medicine
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print patients full name) Birth date (Mo/Day/Yr)

_____ _____
(Street address) Social security number

_____ _____
(City, state, zip code) Phone (Home)

At the request of the individual, I _____, do hereby authorize _____to release:
(Patients Name) (Name of Facility)

DATES OF_____

_____DISCHARGE SUMMARY _____PATHOLOGY REPORTS _____EMERGENCY REPORTS
_____HISTORY & PHYSICAL _____LABORATORY REPORTS _____OTHER_____
_____PROGRESS NOTES _____RADIOLOGY REPORTS _____
_____OPERATIVE NOTES _____ECG/EEG/CARDIC CATH _____ _____

_____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____CHANGE OF DOCTOR
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL _____ CONTINUING CARE
OTHER (SPECIFY)_____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal Representative of patient's estate **Date**

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. HealthPort has been contracted to provide this service and will invoice you directly.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE_____ LAB_____ EKG_____ _____
DS_____ EKG_____ IMMUNE_____ ROI SPECIALIST
OP_____ X-Ray_____ OTHER_____ _____
HP_____ PATH_____ _____ DATE
NUMBER OF PAGES_____ _____

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CHANGE OF DOCTOR INFORMATION

PLEASE READ THE FOLLOWING INFORMATION

TERMS AND CONDITIONS FOR TRANSFER
I AM TRANSFERRING TO ANOTHER PRIMARY CARE PHYSICIAN (PCP) DUE TO THE FOLLOWING REASONS:
PLEASE CHECK ONE

- ☐ CHANGING HEALTHCARE INSURANCE AND PHYSICIANS OF FAMILY MEDICINE PROVIDERS ARE OUT OF NETWORK
- ☐ MOVING OUT OF THE AREA
- ☐ DUE TO PERSONAL REASONS CONCERNING MY PROVIDER OR THE STAFF

I UNDERSTAND THAT IF I AM TRANSFERRING TO ANOTHER PCP DUE TO PERSONAL REASONS CONCERNING MY PROVIDER OR THE STAFF, THEN I WILL NO LONGER BE CONSIDERED A PATIENT AT PHYSICIANS OF FAMILY MEDICINE AFTER THE DATE INDICATED BELOW. UPON WRITTEN AUTHORIZATION, WE WILL PROVIDE COPIES OF YOUR MEDICAL RECORDS TO YOUR NEW PCP. THERE WILL BE A CHARGE TO YOU FOR THIS SERVICE.

I have read the above and authorize the disclosure of the Terms and Conditions for Transfer.

Signature of Patient/Guardian/Patient Representative:	Date:
Signature of Manager/Witness:	Date: