Encompass Family Medicine
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# Authorization to Disclose Medical Records

**Completed by (For office use only):** Chart #: _____

Initials: _____ Date: _____

## Patient Information

Patient's Name: _____

Patient's Address: _____ D.O.B: _____

City: _____ State: _____ Zip: _____ Phone #: (  )_____

## Release of Information

*I hereby authorize Encompass Pediatrics to:* ☐ **Send my medical records to:** ☐ **Request my medical records from:**

Name/Facility: _____ Attention: _____

Address: _____ Phone: _ _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: ☐Personal ☐Continuing care (Referral/2nd Opinion) ☐Legal ☐ Insurance

☐Transfer of care (New Physician) ☐Other:_____

*Transfer reason: ☐Insurance ☐ Dissatisfied with the provider ☐ Moving

## Information to be Released

***Date range requested: From:_____ to _____(mm/dd/yyyy)***

☐Well Visit Notes ☐Growth Charts ☐Sick Visit Notes

☐Lab reports ☐Radiology Report(MRI) ☐Immunization Records

☐All Medical Records ( Additional medical record fee maybe applicable)

## Sensitive Health Information

***The following items will be included unless you initial in the space provided.***

☐Abortion Inital: _____

☐Alcohol/Drug Abuse Treatment Inital: _____

☐Genetic Testing Inital: _____

☐Sexually Transmitted Disease(HIV/AIDS) Results Inital: _____

☐Psychiatric Health Inital: _____

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| ☐ Within two weeks Basic Fee: $25 | After the first 75 pages, there will be an additional 20cents per page, that is charged.<br>Please note, a copy of patient's last physical exam, immunization records will be faxed over earlier to ensure continuity of care. |

- *I understand that authorizing the disclosure of this health information is voluntary. This form need not be signed in order to assure treatment.*
- *I understand that my health record may contain general information related to my mental health, drug/alcohol abuse, or other information that I may consider sensitive. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal confidentiality rules.*
- *I understand that I have a right to revoke this authorization at any time by providing a written statement to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand this authorization is valid for 90 days unless otherwise specified or revoked. Please specify an expiration date if less than 90 days: ____/____/_____.*
- *I understand that I am responsible to pay any amount( basic and additional) associated with the medical record fee generation.*
- *I understand that my health record may contain general information related to my mental health, drug/alcohol abuse, or other information that I may consider sensitive. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal confidentiality rules.*
- *I understand that Encompass Pediatrics LLC or any of its contractors and employees are not liable for any re-disclosures that may occur outside the clinic premises.*

Signature of Patient/Legal Representative Signature: _____

Print Name of Legal Representative: _____

Relationship to Patient: _____

Date: _____