One Family medical group

RECORDS RELEASE FROM ANOTHER PROVIDER

Patient name _____ Date of Birth _____

I hereby authorize and request the below provider to release complete medical records to One Family Medical Group

Healthcare Provider _____
Mailing Address/City _____
State/ZIP _____
Fax Number _____

concerning my illness and/or treatment from _____ to _____.

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist.

____ Please send the entire medical record (all information) to the above named recipient.

____ HIV/AIDS-related records (**must be initialed to be included in other documents**)

____ Mental health information (**must be initialed to be included in other documents**)

____ Genetic testing information (**must be initialed to be included in other documents**)

____ Other _____

_____

____ Drug/alcohol diagnosis, treatment or referral information (federal regulation requires a description of how much and what kind of information is to be disclosed)

_____

_____

Patient Signature _____ Date _____

Witness _____ Relationship _____

This information is personal, confidential and privileged information intended for the named recipient only. Any disclosure, copying, distribution, or the taking of any action in reliance on the contents of the information in this release is prohibited. If you have received this document in error, please notify us immediately and destroy the document. Thank you.

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