RELEASE (Authorization) TO COPY MEDICAL RECORDS FORM

I authorize records to be released **FROM**: _____

(address): _____

I authorize records be sent **TO**: _____

(address): _____

I authorize the following records to be copied (by means of mail, fax, or electronic) :

I authorize the release (copy) of my private medical records regarding my medical history, illness or injury, consultations, prescriptions, treatment, diagnosis, prognosis, test results (lab and radiology), including records from my other health care providers that my current healthcare provider may have.

☐ Entire record (all records, including: genetic testing, HIV testing / diagnosis / treatment, alcohol and drug / substance abuse treatment, psychiatric / mental health records).

☐ Limited - all records but excluding: _____

☐ Limited to the following specific medical information:

- ☐ operative and pathology report from surgery: _____
- ☐ most recent history and physical
- ☐ most recent pap smear
- ☐ emergency department visit records (including labs and radiology)
- ☐ other: _____

I understand that I have the right to revoke this authorization at any time; that unless otherwise revoked, this authorization will not expire. I understand that I can refuse to sign this authorization. I understand that I may inspect the information to be copied. A photocopy or facsimile of this authorization will be considered as effective and valid as the original. I understand that there will be a fee to copy my records.

For records released <u>from</u> Amber Health Care for Women: Our office is contracted with Professional Medical Copy (copy service). Professional Medical Copy abides by the guidelines of Health Insurance Portability and Accountability Act (HIPAA) and the protection of Health Information (PHI). Professional Medical Copy will invoice me for their services and I agree to pay for their services. Fees include: a clerical fee of $8.25, a handling fee of $3.75, a page copy fee of $0.10 per page, plus shipping.

_____

Signature of patient (or legal representative - list relationship to patient) Date

_____

Name of patient (PRINT) Patient's Social Security Number Patient's Date of Birth