Records Release Form

Authorization for use or disclosure of health information

PRIMARY MEDICAL

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization. I understand that I have a right to receive a copy of this Authorization.

Patient Name *

First | Last

Date of birth *

MM/DD/YY

I authorize Primary Medical at: *

Please Select your Primary Medical office

Email: Documents@primarymedical.net

To: *

☐ Release my records ☐ Receive my records

☐ Check box if you prefer records in electronic form.

Send my records to/request my records from: *

Facility Name

Street Address

City/State/Zip

Phone | Fax

☐ I would like to request my records from more locations.

Please send records for the following date or date range *

Ex: 2016 - present

Please release the following types of records: *

- [ ] All records
- [ ] Progress Notes
- [ ] Other tests and procedures
- [ ] Labs and Radiology
- [ ] Immunization records
- [ ] Other
- [ ] Consultation Notes

The purpose of this requested disclosure is:

Ex: Continuation of care

I specifically authorize release of the following information (check and initial as appropriate):

- [ ] Mental health treatment information
- [ ] HIV test results
- [ ] Alcohol and drug treatment information

If not checked, the records containing such information can NOT be released.

Duration: This Authorization expires one year from the signature date.

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to Primary Medical. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Re-disclosure: Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

Conditioning: I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

Fee for records: We may charge a fee of up to $25.00 for the release of records. There is no fee to release records to another doctor or medical facility.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003

Signature *

×

draw type

Today's Date *

11/4/2022

Relationship to patient

Self

Submit