PARTNERS IN HEALTH
FAMILY MEDICINE

Transfer of Medical Records

Patient Information- Please Print
Name: _____
Date of Birth: _____
Phone #: _____

Release FROM:
Name: _____
Address: _____
_____
*Phone #: _____
Fax #: _____

Release TO:
Name: _____
Address: _____
_____
*Phone #: _____
Fax #: _____

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION FOR CONTINUITY OF MEDICAL CARE
Any facsimile, copy or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

☐Entire Record: If so, Why? _____
☐Office Visits: From _____Until _____
☐Labs: From: _____ Until _____
☐X-Ray Reports: From _____Until _____
☐Diagnostic Studies: From _____Until _____
☐Hospital Reports: From _____Until _____
☐Consults: From _____Until _____
☐Medication List
☐Other: _____

Purpose of release: _____

_____ _____

Signature of Patient of Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

KGH 3/4/15