Primary Care Physicians, LLP
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Request for Release of Medical Information

Make sure all information if complete to prevent a delay in release of information. Please print.

Patient Name:_____ **Date of Birth:** _____

Address:_____

Phone Number:_____ **Previous Name(if applicable)**_____

This will authorize: (Provider)

_____

_____

_____

_____

To release to: (Provider)

_____

_____

_____

_____

The following information:

- ☐ Complete medical records
- ☐ Lab reports - date(s)_____
- ☐ X-ray reports-date(s)_____
- ☐ Progress notes-dates _____
- ☐ Other_____

For the following purposes:

- ☐ To update my PCP
- ☐ I have been referred to another physician
- ☐ I want/need a second opinion
- ☐ I am changing doctors (providers) due to:
  - ☐ Insurance Change
  - ☐ Dissatisfaction with care
  - ☐ I am moving to new address
- ☐ Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I specifically authorize the release of data and information relating to: (check any that apply)

- ☐ HIV related information (AIDS related testing)
- ☐ Mental Health Information
- ☐ Drug or alcohol Information

This authorization will be valid for 90 days from the date of signature or until _____. This consent may be revoked at any time by notifying the above named provider. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

Restrictions: This authorization is being given with the understanding that the receiver my not further use of disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically permitted by appropriate state or federal law.

_____ _____

Signature of Patient or Legal Guardian
(Needed for minors: NE-under age 18; IA-under age 18

Date Signed

_____

Relationship to patient, if not the patient