



# Medical Records Release Authorization

Upon presentation of this authorization you are requested to provide the records outlined below to:

**To Recipient:**  
(who/where are the records going)

Person/Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**From Clinic/Hospital:**  
(Where are the records coming from)

FAX # \_\_\_\_\_

**Patient:**

Patient Name \_\_\_\_\_ Phone /Email \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Dates of Service (Check One and Complete Dates of Service if Required)**

**Records to be Released (45 CFR § 164.508(c)(1)(i)).**

Please provide a complete copy of my file for all dates of service

Please provide a complete copy of my file for service from \_\_\_\_\_ through \_\_\_\_\_

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> All Medical Records   | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Operative Report   | <input type="checkbox"/> Discharge Summary    |
| <input type="checkbox"/> Lab/Pathology Reports | <input type="checkbox"/> Radiology Reports  | <input type="checkbox"/> Images               |
| <input type="checkbox"/> Itemized Billing      | <input type="checkbox"/> Other _____        |   |

**Purpose for Disclosure**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Disability          | <input type="checkbox"/> Insurance       | <input type="checkbox"/> Attorney                    |
| <input type="checkbox"/> Referring Physician | <input type="checkbox"/> Patient Request | <input type="checkbox"/> Other (please state reason) |

Other \_\_\_\_\_

**Please indicate your acceptance by checking the following boxes:**

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time. By signing this I understand the process could take anywhere from 10-14 business days to complete.

**Please indicate how you would like records to be sent: Fax [ ] Mail [ ] Pick up [ ] Patient Portal [ ]**

To check status, please call (800) 659-4035 or email [status@healthmark-group.com](mailto:status@healthmark-group.com)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative