St. Joseph Physician Associates

Medical Record Release Form

Name:______________________________________ DOB:_________________ SS:____________________

Address:____ Phone:__________________________

From/To (*please circle intended direction)*

Name:	Phone ( )	Fax ( )
Address:		

From/To (*please circle intended direction*)

Name:	Phone ( )	Fax ( )
Address:		

Purpose of Disclosure:

□ Continuity of Care	□ Insurance	□ Legal	□ Personal Use
□ Transfer of Care	□ Other (please specify):		

Records to include:

This authorization pertains to the disclosure of record types indicated below between following dates of service: From:_______________________________ To:___________________________ OR ☐ All records retained by this facility

□ Progress Notes	□ Lab Notes	□ Immunization Records	□ Operative Reports
□ Hospital Records	□ Imaging Records	□ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____________***Initials***

Expiration: This authorization shall expire 180 Days from date of signature.
I understand that this authorization may be revoked by me at anytime except to the extent that action has been taken. I have the right to revoke this Authorization at any time prior to 180 days by giving the healthcare provider written notice of revocation of this Authorization. _____________***Initials***

Re-disclosure: I understand the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

I understand that:

- I have the right to refuse to sign this Authorization
- I have the right to receive a copy of this Authorization
- I have the right to inspect or copy the protected health information to be used or disclosed
- Fees/charges will comply with all laws and regulation applicable to release of information

I have read the above and authorize the disclosure of the protected health information as stated.

___________________________	__________________________________	___________________________
Date	Signature of Patient/Parent/Guardian	Relationship to patient