Avance Care®

Your Healthcare Simplified.™

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____ Date of Birth: ____/____/________

Phone ______________________ Email: _______________________________ (mm/dd/yyyy)

Legal Guardian name: ____ Relationship to Patient: __________

I request a copy or summary of the following medical records:

☐ Complete Medical Record* ☐ Immunization Record* ☐ Lab Report(s) ☐ X-ray Reports

☐ Electrocardiogram ☐ Allergy Records ☐ Surgical Procedures ☐ Other __________________

Required if transferring records to Avance Care

For dates of service from ____/____/____ to ____/____/____

Purpose of Release:

☐ Transfer of Care ☐ Moving Out of Area ☐ Legal ☐ Specialist Consultation

☐ Insurance Claim ☐ Workers' Compensation Claim ☐ Personal ☐ Other ____________

Select One:

☐ **Request to transfer records TO Avance Care FROM the office listed below**

OR

☐ **Request to transfer records FROM Avance Care TO the office listed below**

Please allow 15 business days for processing. Incomplete information will delay processing.

Office Name: ____________________________________

Address: ____________________________________

Phone: __________________________ Fax: ________________________

Avance Care location to have records to be faxed to or to be faxed from:

Avance Care Location Name: ____________________________________

Address: ____

Phone: __________________________ Fax: ________________________

- I understand that my health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and treatment for alcohol and/or drug abuse. Accordingly, I specifically authorize release of the following information:

  ☐ Yes ☐ No Mental health and/or psychiatric treatment records

  ☐ Yes ☐ No Substance abuse (drug and/or alcohol) treatment records

  ☐ Yes ☐ No Sexually transmitted disease information

  ☐ Yes ☐ No HIV/AIDS – related information

- I understand that authorizing the disclosure of the protected health information is voluntary. I need not sign this form to assure treatment. I understand that once my protected health information is disclosed pursuant to this authorization, the information is subject to potential re-disclosure by the recipient and may no longer be protected by federal privacy laws.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that such a revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____

  If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days.

Signature: ____ **Date:** ________________________

Patient or Legal Guardian