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* ☐ Immunizations ☐ Lab Report(s) ☐ Imaging Reports

☐ Behavioral Health/Therapy ☐ Nutrition ☐ Allergy ☐ Other _____

Excludes Behavioral Health and Nutrition Records

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 <u>TO</u> Avance Care <u>FROM</u> the office listed below**

☐ **Request to transfer records <u>FROM</u> Avance Care <u>TO</u> the office listed below**

☐ **Request to transfer records to myself (patient or legal guardian) for personal use***

Must sign Informed Consent To Accept Medical Records For Personal Use form (see second page)

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

Office Name: _____

Address: _____

Phone: _____ Fax: _____

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

AvanceCare

INFORMED CONSENT TO ACCEPT MEDICAL RECORDS FOR PERSONAL USE
(To be filled out only if records are transferred to patient or legal guardian)

By signing below, I am acknowledging that I have been fully informed that it is contrary to medical advice that my records be released but I wish to proceed against the professional guidance that I have been given. By initialing after each bullet point, I am acknowledging that the following are examples of a few reasons why this practice is not generally recommended for records, psychological records in particular. The following examples are certainly not exhaustive and additional negative unforeseen consequences may apply to my case:

- Once released, these records may end up in the hands of people not obligated to follow HIPAA and other practices for protecting records _____ (Initial)
- Once released into a legal process, these records may lose their confidential status entirely, even potentially becoming public knowledge or used against you _____ (Initial)
- When reviewed in the absence of professional guidance, e.g., physician or your current therapist, portions of the records could be misunderstood, misused, etc. and could cause emotional distress or other harm _____ (Initial)
- Once released, you may lose options for protecting them that your attorney could have exercised, if you had obtained appropriate legal guidance prior to obtaining the records _____ (Initial)
- Even when your records are demanded by subpoena, you may not be obligated to turn them over and turning them over may unnecessarily expose your personal information _____ (Initial)
- Allowing your information to fall into others hands may not only place you at risk for harm but might also place others at risk for retaliatory actions _____ (Initial)

By signing below, I am acknowledging that, in spite of the potential risks to myself and others, I am electing not to have my records sent directly to a healthcare professional or attorney but wish to take them into my personal possession.

Signature: _____ **Date:** _____

Patient or Legal Guardian

Address: _____

City: _____ **State:** _____ **Zip:** _____