First Internal Medicine, Prof. LLC
Consultation and Concierge Medicine

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REQUEST FOR RECORDS RELEASE

Physician or Practice Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #:_____ Fax #:_____

Dear Doctor:

The following individual is requesting that <u>all his or her medical records</u> be released and forwarded to our office. Please fax the records to the number shown above. You can also send us an electronic copy of the records on CD/DVD. Thank you for expediting this request.

Patient Authorization

Patient Name: _____ Date of Birth: _____

Previous name (if applicable): _____

I hereby authorize the release of **ALL MY HEALTH RECORDS** to First Internal Medicine. Handle the specific types of records according to my preferences as follows: (circle 'Include' or 'Exclude')

> Include or Exclude   My health information related to alcohol or drug abuse

> Include or Exclude   My health information related to HIV/AIDS

> Include or Exclude   My health information related to psychological or psychiatric conditions

> Include or Exclude   My health information related to genetic testing

The reason for this request is (check one):

☐ I am transferring care to **First Internal Medicine** as my new primary care physician (PCP).

☐ I am consulting with **First Internal Medicine**. Please keep my records active as I will remain a patient in your office.

This authorization ends: _____ (if no date is given, the authorization will be valid for one year from the date signed)

I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. Two ways to revoke this authorization are: a) fill out a revocation form; b) write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____   _____
Patient or legally authorized individual signature   Date Signed

_____   _____
Printed name if signed on behalf of the patient   Relationship (parent, legal guardian, power of attorney, etc.)