Name of Practice: First Internal Medicine, Prof .LLC – Igor Huzicka, MD& Tamara Murphy, PA-C

Acknowledgement of Termination of Care and Request to Receive a Copy of Medical Records

Patient name: _____ Date of birth: _____

Previous name (if applicable):_____

I. Authorization

I hereby acknowledge that Dr Huzicka and First Internal Medicine will cease providing outpatient medical care services on November 27, 2019.

In order to establish care with a new physician, **I hereby wish to receive a complete copy of my medical records.**I understand that it will be my responsibility to provide these medical records to my new physician. I also understand that, unless I circle "Exclude" below, I will receive a complete copy of all my medical information maintained by First Internal Medicine which may include any of the following:

My health information related to alcohol or drug abuse	Exclude
My health information related to HIV/AIDS	Exclude
My health information related to psychological or psychiatric conditions	Exclude
My health information related to genetic testing	Exclude

In accordance with federal regulations (HIPAA, 45 CFR 164.524), First Internal Medicine or its authorized representative will prepare the records for delivery within 30 days of the receipt of this request.

Once the records are ready, I would like to receive them as follows:

- ❑ Please mail the records to the following address:

  Street: _____ Apartment # _____

  City: _____ State: _____ ZIP: _____
- ❑ If the records are available before the office closes on 11/27/2019, I would prefer to pick up the records in person in the office. Please notify me by telephone _____ and/or via email _____ when the records are available for pickup.

II. My Rights

I understand that First Internal Medicine will store and eventually dispose of my health information in accordance with all applicable federal and state privacy and security laws and regulations.

I may request that First Internal Medicine sends a copy of my medical records directly to my new physician(s) or a third party of my choice.

I understand that First Internal Medicine will disclose my health information, unless otherwise allowed by law, **only with my written consent** provided by HIPAA-compliant authorization. A copy of such *Authorization to Use or Disclose My Health Information* is available for download at www.denvermd.net or from First Internal Medicine at (303) 799-1443 or denvermd@denvermd.net.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)