Painted Rock Family Medicine

Balanced Healthcare for a Balanced Life

Transfer of Medical Records

Patient Name:_____DOB:_____Phone#:_____

Reason for Release:

___ Moving __ Out of State ___within Colorado __Provider Retiring

___ Dissatisfied with Practice Provider ___Insurance __Continuity of Care

___ Other:_____

Release From:

Name:_____

Address:_____

_____

_____

_____

Phone:_____

Fax:_____

Release To:

Name:_____

Address:_____

_____

_____

_____

Phone:_____

Fax:_____

I request and authorize this transfer and release of my medical record to and from the medical practice listed above. I understand that this document includes all forms of Protected Health Information (PHI) and is also applicable to the electronic transfer of records if the requested recipient is able to accept and access encrypted information from Painted Rock Family Medicine Record. I understand that I may not be denied treatment or payment for health care services if I do not sign this form.

___ Entire Medical Record ___ X-Ray reports ___ Medications

___ Doctor Notes ___ Laboratory findings ___ Diagnoses

___ Pathology Reports ___ Diagnostic Studies ___ Other: _____

Due to the sensitivity of the following information, please check off and initial if you would like the following information released:

___ Notes and reports related to STDs including HIV/AIDS Initial:_____

___ Psychiatry/Mental Health Notes Initial:_____

___ Notes related to Drug/Alcohol Abuse Initial:_____

I understand that Painted Rock Family Medicine will not longer be responsible for the protection of the PHI except in its original format in their records. I understand that my Health Information may be subject to be disclosed by the recipient and if the recipient is not a health plan or health care provider. The Information may no longer by protected by the Federal Privacy Regulations. This authorization will expire one year from the date I sign. I understand the right to revoke this authorization at any time. If I revoke, I must do so in writing. I understand the revocation will not apply to information already released. I understand the revocation will not apply to my insurance company, when the law provides my insurer with the right to contest a claim under my policy.

Patient Signature:_____ Date:_____

Signature of Authorized Representative (if unable to sign)_____

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