PATIENT REQUEST FOR MEDICAL RECORDS TRANSFER

Authorization for Release of Protected Health Information (PHI)

Name of Patient: ______________________________ Soc. Security #: ________________
Address: ____________________________________ Phone Number: ________________
____ Date of Birth: __________________
Email Address:____

<u>Reason for Medical Records Release**:</u>**

☐ Personal Copy ☐ Transfer Providers ☐ Move ☐ Attorney/Legal ☐ Insurance ☐ Continuity of Care

Delivery method: ☐ Pick up in Person ☐ US Mail (when applicable) ☐ Fax__________________
Date Range of Health Records to be Released _________________ (OR) All Date Ranges _______

****Please Complete this section ONLY if a Personal Copy has been requested****

PFMDC can Release PHI To: ___ Patient ___ Parent / Guardian ___ Organization/Insurance/Lawyer
Name: ____________________________ Relationship to Patient: _________________
Address: ___________________________ Phone Number: _______________________

Type of Request:

1.) **Medical Records Transfer to PFMDC** ☐

I hereby request that ____ (Current Provider Info.)
transfer my health record information to **<u>Person Family Medical and Dental Center</u>**
Address: 702 N. Main St. Roxboro NC 27573 Phone: 336-599-9271 Fax: 336-599-0969
Email Address: records@pfmcinc.org

***Description of Records to be Released to PFMDC: (Check ALL that apply)**

___Entire Medical Record ___Consultation Notes ___Operative Reports ___Billing Records
___ER Record ___History and Physical ___X-Rays Reports ___All Records ___Outpatient Record
___Pathology Reports ___EKG/EEG ___All Signed Consents ___Discharge Summary
___Progress Notes ____Lab Reports ___Other (Specify) ________________________________

** I also give consent that all past, present, future Medical Providers release the following medical records to PFMDC in regards to my healthcare** _____ YES _____ NO

2.) **Medical Records Transfer from PFMDC to another Healthcare Provider/Facility/Other** ☐

I hereby request that **<u>Person Family Medical and Dental Center</u>** transfer my health record information to the following Provider's office: ____
Address: ____ Phone:___________________
I ask that PFMDC provide the following Protected Health Information as outlined below (health records).

***Description of Records to be Released (Check ALL that apply)**

___Entire Medical Record ___Consultation Notes ___Operative Reports ___Billing Records
___ER Record ___History and Physical ___X-Rays Reports ___All Records ___Outpatient Record
___Pathology Reports ___EKG/EEG ___All Signed Consents ___Discharge Summary
___Progress Notes ____Lab Reports ___Other (Specify) ________________________________

3.) **Specific Confidential PHI Authorized for This Release:**

****Please complete this section for all Medical Records Release Requests****

I am authorizing ____________________________ (Practice or Hospital) to release the indicated type of information pursuant to this **Authorization from the treatment date(s) listed above.**

___HIV/AID Related Information ___Drug and Alcohol Information ___Genetic Information
___Mental Health & Psychotherapy Information ___Sexually Transmitted Disease Information
___Tuberculosis Information

This signed Authorization will expire in **one year** from the date signed unless an earlier date is indicated.
Alternate date: _______________ Initials: __________________

I understand that I may revoke this authorization by sending a letter to ____________________________ (Name of Healthcare Provider) at the address listed above.

** This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
** I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

The HIPAA Privacy Rule permits a covered entity to disclose PHI, including psychotherapy notes, when the covered entity has a good faith belief that the disclosure: (1) is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others and (2) is to a person(s) reasonably able to prevent or lessen the threat. This may include, depending on the circumstances, disclosure to law enforcement, family members, the target of the threat, or others who the covered entity has a good faith belief can mitigate the threat. The disclosure also must be consistent with applicable law and standards of ethical conduct. See 45 CFR § 164.512(j)(1)(i). I have read and signed this authorization.

*Signature ____ *Date __________________
*Relationship to Patient ___________________________________

Reference:

520-Does HIPAA permit a provider to disclose PHI about a patient if the patient presents a serious danger to self or others. (2008, November 25). Retrieved April 12, 2016, from http://www.hhs.gov/hipaa/for-professionals/faq/520/does-hipaa-permit-a-health-care-provider-to-disclose-information-if-the-patient-is-a-danger/