

REQUEST FOR RELEASE OF MEDICAL RECORDS

The purpose of this form is to obtain authorization for use or release of protected health care information. Patients have the right to receive one free copy of their medical records. There will be a charge for any additional requests.

I, _____, authorize the entity listed below to release medical records for the following patients.

You may email this completed form to records@bgimp.com

PLEASE DO NOT FAX MEDICAL RECORDS

PATIENT INFORMATION:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

<p>Records From:</p> <p>_____</p> <p>Doctor or Group Name</p> <p>_____</p> <p>Mailing Address</p> <p>_____</p> <p>City, State & Zip Code</p> <p>_____</p> <p>Phone Number & Fax Number</p>

<p>Records To:</p> <p>_____</p> <p>Doctor or Group Name</p> <p>_____</p> <p>Mailing Address</p> <p>_____</p> <p>City, State & Zip Code</p> <p>_____</p> <p>Phone Number & Fax Number</p>

INFORMATION REQUESTED:

_____ All health care information, including all mental health records.

_____ All Immunization Dates and Growth Charts

_____ Health care information relating to the following treatment, condition, or date of treatment:

_____ Other: _____

For the purpose of: _____ Transfer of Care _____ For Specialist Visit _____ Moving or Relocation

I hereby request and authorize the release of requested health care information from the above named party to the corresponding above named party. This authorization will expire 60 days from the date signed. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Bowling Green Internal Medicine & Pediatric Associates.

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Guardian

Relation to Patient