BAPTIST PRIMARY CARE
MEDICAL RECORDS REQUEST OR RELEASE

RELEASE OF RECORDS

Records to be sent to the following address:

NAME:_____

ADDRESS: _____

_____

Reason for Release of Records: _____

REQUEST FOR RECORDS

Records to be received from:

PHYSICIAN/FACILITY: _____

ADDRESS: _____

_____

Release from my medical records the following information for the following dates: From: _____
To: _____

_____

_____

As part of the medical record, the following information will be released unless stricken:

SEXUAL ABUSE INFORMATION
DRUG & ALCOHOL ABUSE INFORMATION
CHILD ABUSE & NEGLECT INFORMATION
PSYCHIATRIC INFORMATION
AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed: _____ Date: _____
(Patient, Parent or Guardian)

Patient Name: _____ DOB: _____ SS#:_____

Witness: _____ Date: _____

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.