MEDICAL RECORDS RELEASE FORM

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT IDENTIFICATION:

Name_____
Date of Birth _____Phone _____

PROVIDER:
(Who is releasing the information)

Name_____
Address_____
City_____ State_____Zip_____
Phone _____Fax_____

REQUESTOR:
(Where do you want the information sent)

Name_____Phelps Medical Group_____
Address_____1315 Tibbals Street_____
City_____Holdrege_____State_____NE _____Zip__68949_____
Phone _____308-995-6111_____Fax_____308-995-4868_____

INFORMATION REQUESTED:

Date of Appointment :_____

- ❑ Complete Records
- ❑ Lab Data, Date_____
- ❑ X-ray Data , Date_____
- ❑ EKG, Date_____
- ❑ Progress Note ,From_____ To_____
- ❑ History & Physical, Date_____
- ❑ Discharge Summary, Date_____
- ❑ Immunization Record_____
- ❑ Other, specify_____

A specific authorization is required to release the following information:
Initial _____ ❑ **HIV** ❑ Drug/Alcohol Information ❑ Mental Health

PURPOSE OF RELEASE:

- ❑ At my request
- ❑ Insurance coverage
- ❑ Transferring Medical Care
- ❑ Moving
- ❑ Other, specify_____

SIGNATURE OF PATIENT _____DATE_____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT_____

This authorization is effective for 180 days from the date on which it is signed. I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Phelps Medical Group based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatments, payment, enrollment in a health plan, or eligibility for benefits. I understand that if the person or entity receiving authorized information is not a health plan or health care provider, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Medical records released directly to the patient are the patient's responsibility and may no longer be protected by federal or state law. *<u>If records are needed by a certain date, please fill in the appointment date in the space provided.</u>*

Phelps MEDICAL GROUP