TRANSCEND MEDICAL GROUP

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MEDICAL RECORD RELEASE REQUEST

PATIENT NAME: ____
last first middle

ADDRESS: ____

____
city state zip

SOCIAL SECURITY # ____________________ SEX: M F DATE OF BIRTH: ____________________

HOME # ____________________ CELL # ____________________ WORK # ____________________

The following person or facility is authorized to provide copies of the patient's identifiable health information:

RELEASE FORM: NAME: ____

ADDRESS: ____
city, state, zip code

PHONE # ____________________ FAX # ____________________

SEND TO: NAME: ____

ADDRESS: ____
city, state, zip code

PHONE # ____________________ FAX # ____________________

PURPOSE FOR RELEASING THE INFORMATION:

☐ Moving Away from Area ☐ Transfer of Care ☐ At Request of Patient ☐ For Patient Care

DESCRIBE THE INFORMATION THAT IS TO BE RELEASED:

☐ Office / Treatment Notes ☐ Lab Reports ☐ X-Ray / CT Reports / MRI / Ultrasound ☐ EKG

☐ Other: ____

INDICATE THE DATES OF SERVICE THAT IS TO BE RELEASED:

☐ Entire medical records for services rendered at this office. ☐ Last office visit, laboratory and / or x-ray test results

☐ Other (please specify): ____

I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record. I understand that if the person or facility receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Note: The revocation my be in writing and delivered to the above address of the person / entitiy of whom was to release information. I understand that unless earlier revoked, this authorization will expire 30 days after the date signed. I understand that there may be a charge for obtaining the requested information. Related charges can be obtained by contacting the medical records department. I understand that I have the right to obtain a copy of this authorization.

SIGNATURE ______________________________ DATE: ____________

Or Legal Representative of Patient: ______________________________ DATE: ____________
Attach Legal Representative Document

WITNESS: ______________________________ DATE: ____________

(OFFICE USE : DATE RECORDS SENT: ______________________________ BY: ____________