Authorization for Release of Medical Records

Date of Request: ______________________________ **Date of Birth:** ______________________________

Name: ____

Address: ____

City: ______________________ **State:** ______________ **Zip Code:** ___________

Home Phone: ______________________________________ **Cell Phone:**_______________________________

Email: ____

TO RELEASE INFORMATION TO: (who do you want to receive your records):

____ ____________________ ________________

(Name of person or medical facility) **Phone** **Fax**

Information to be released: (check all that apply):

My medical records for the dates _____/_____/_____ to _____/_____/_____

My complete medical record

Lab Reports Pathology Reports History and Physical Exam(s) Imaging Reports

Implant details Physician Office Records EKG/Cardiac Reports Photos

Other records ____

****Release of the following information may be governed by additional laws. I am aware and agree that this information will be disclosed only if circled**.

•Mental health information •Drug/alcohol diagnosis, treatment, or referral information •HIV/AIDS information
• Genetic testing information

Purpose of Disclosure: (please mark all that apply)

At my (patient) request Changing physicians Continuing care

Insurance eligibility/benefits Legal Second opinion

Other (specify): ____

I understand that once Palo Verde Plastic Surgery discloses my health information to the recipient, Palo Verde Plastic Surgery cannot guarantee that the recipient will not redisclose my health information to a third party. I release Palo Verde Plastic Surgery, its employees and agents, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

I understand that I may be charged a $25 fee for copies of my medical records if I am requesting it for my personal use in accordance with the state law. I understand that it can take up to 30days to receive. I understand that I may request a copy of this signed authorization and that this authorization is my choice, and it will not affect my treatment from Dr. John Rowley. I may take back this authorization, in writing, at any time with the understanding disclosure may be made before I take it back. Unless otherwise revoked, this authorization will automatically expire one (1) year from the date signed.

I understand that these records may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I am aware the recipient may re-disclose these records. In such a case, they may no longer be protected by HIPAA. My records may be protected under state law. They cannot be disclosed without written consent. It can only be disclosed if it is provided for in the law and/or regulations.

My signature confirms that I have read, understood, and authorize the release of the information described in above.

____ _____________________________
PRINT PATIENT NAME LEGIBLY DATE

____ _____________________________
PATIENT SIGNATURE DATE

Authorized Representative* making request (if other than the patient):

____ _____________________________
PRINT NAME LEGIBLY RELATIONSHIP

____ _____________________________
REPRESENTATIVE SIGNATURE DATE