PATIENT INFECTION AND INFUSION CARE CENTER
MEDICAL RELEASE PF PROTECTED HEALTH INFORMATION

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Patient Name _____ Date of Birth_____

Address_____Phone_____

Purpose of Release: **[ ] Transfer out of Practice [ ] Insurance [ ] Coordination of Care [ ] Personal**

IF RECORDS ARE NEEDED FOR AN APPOINTMENT , GIVE THE DATE OF THE APPOINTMENT:_____

Physician **to release** records:

Name _____

Address _____

Phone _____

Fax _____

Physician/Person **to receive** records:

Name _____

Address _____

Phone _____

Fax _____

RECORDS REQUESTED:

- ☐ Entire medical records, ***including*** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases and HIV/AIDS

- ☐ Entire medical records, ***excluding*** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS

- ☐ Records of care from_____ to _____ ***including*** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases and HIV/AIDS

- ☐ Records of care from_____ to _____ ***excluding*** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to testing or treatment of sexually transmitted diseases and HIV/AIDS

- ☐ Other _____

- ☐ If deemed necessary by doctor _____, I authorize this form to be sent via FAX transmission.

This consent applies to all information in my records protected under the regulations in 43 CODE of Federal Regulations Part 2. I understand that if I release my records to another person or provider, they can release my medical record. I know I need to check with them about their privacy rules. I authorize the above medical information to be released as indicated above. I understand this release is effective (date) _____; but that I may revoke my consent at any time providing written consent to the above-named party.

Patient or Legal Guardian Signature Date

Witness Signature Date