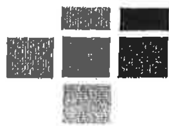

PRIMARY CARE, PLLC

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Medical Records Release Request

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Your Name ____

Address ____

Home phone: ________________ **Work phone:** ____________ **Cell Phone:** ____________

DOB: ________________ **Social Security #:** ____________________________

Requesting Provider: ____

Please transfer my medical records* as follows via mail, e-mail or fax:

From: ____________________ **To:** ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

For the following dates: ________________ **to** ________________

***Records to be released:**

__ Annual exam and Pap smear / Prostate
__ Labs/X-ray
__ All medical records
__ Billing Statements
__ Other ____________________________

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STD test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

Patient/Guardian Name & Signature: ________________________________ Date: __________

Witness Name & Signature: ________________________________ Date: __________