Authorization for the Release of Medical Records

Where are the records being released from?

Facility Name: Provider Name(s):

Address: City: State:

Tell us about the patient.

Name: DOB: SSN: XXX-XX-

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released? Check all that apply.

☐ All Records ☐ Office/Clinic Notes ☐ Operative Reports ☐ Images (X-Ray, MRI, Etc.)

☐ Lab/Pathology Results ☐ Radiology Reports ☐ Immunization Records ☐ Substance Abuse Psychiatric Conditions

☐ Last Two Years of Records ☐ Dates _____ to _____

☐ Other_____

***Notice about sensitive information, in accordance with 45 CFR § 171.204(a)(2):** Duly's electronic medical record system cannot segment (1) Mental Health, (2) HIV/AIDS/STD, (3) Genetic Testing or (4) Drug/Alcohol Abuse "sensitive information" from other information in your medical records. Therefore, this sensitive information will be released to the individual/organization listed on this authorization form.

**** For minors aged 12-17**, the minor's signature is required for the release of Mental Health Records.

Purpose of Disclosure: Why are we sending the records?

☐ Personal Use ☐ Litigation/Legal ☐ Insurance ☐ Continuation of Care ☐ Transfer to New Physician

Delivery Method: How would you like the records sent?

☐ Email ☐ Fax ☐ Pick up at HIM office (you will be notified when ready) ☐ Postage (additional fee applies)

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: Date:

Witness Signature: Date:

Witness required unless transfer of care, records produced to patient or patient directive.