Trinity Family Medicine, LLC

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MEDICAL RECORD RELEASE

PATIENT INFORMATION
Patient Name:_____ Date of Birth:_____
Phone Number:_____
Address:_____

RELEASE INFORMATION FROM: **RELEASE INFORMATION TO:**
Name/Facility:_____ *_____
Address:_____ * _____
Phone#: _____ Fax #: _____

SPECIFIC INFORMATION TO BE RELEASED:
*Information to be disclosed to **Trinity Family Medicine** from **Old PCP,** are not to be in disc, flash drives, nor do we need the entire medical record, please keep for you own reference.

Medical records released must include:

***Problem List * Medication List * Allergy List * Immunization List ***
***Recent Imaging 1-2rs: Colonoscopy /PAP / Mammograms /MRI/CT /Xray**

*****To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do NOT permit this information of this type, if it exits, to be released. I understand that if I do not check the box, Trinity Family Medicine will release such information about me if it exists

___ HIV/AIDS infection ___ Mental Health
___ Sexually transmitted diseases ____ Treatment for alcohol and/or drug abuse

*I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law. It is my understanding that this authorization will expire in one (1) year from date signed below. I understand that I may revoke this authorization by notifying Trinity Family Medicine. I understand that any previously disclosed information would not be subject to my revocation request.

REASON FOR RELEASE:
In an effort to better serve our patients, it is important for us to understand the reason that you are leaving our practice. Please indicate on the line below:

- _____

THIS FORM MUST BE FULLY COMPLETE BEFORE SIGNING

Signature of Patient or Patients Legal Representative: _____

Print Name of Legal Representative: _____

Relationship to Patient_____ Date: _____