PIEDMONT MEDICAL
ASSOCIATES

Medical Records Release / Receive Form

Authorization for Use / Disclosure of Protected Health

Patient full name: _____ Patient phone #_____

Patient date of birth: _____/_____/_____ Patient SSN #_____

Patient current address: _____

_____

I hereby request / authorize Piedmont Medical Associates to:

☐ **Release a copy of my medical records to:**

- or -

☐ **Receive a copy of my medical records from:**

Name of person(s) or medical facility: _____

Address of person or medical facility: _____

Fax # of person or medical facility: _____

Telephone # of person or medical facility: _____

Description of information to be released/received: ** _____ / _____ **Staff Initials & Date**

☐ **ENTIRE MEDICAL RECORD** ☐ **SPECIFIC DATE OF SERVICE:**_____

☐ **OTHER: describe –** _____

**** The health information requested will not include psychotherapy notes, although they may include other sensitive patient health information.

PURPOSE OF AUTHORIZATION / DISCLOSURE OF INFORMATION: ☐ **At the request of patient.** ☐ **Other:** _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. A revocation form may be obtained from Piedmont Medical Associates Health Information Management. The completed revocation must be presented directly to PMA HIM. I also understand that this Authorization is specific to the information noted above and for the purpose written above. Piedmont Medical Associates shall not condition treatment on the receipt of this Authorization except when such conditioning is permitted in instances where the sole purpose of creating the health information is for disclosure to a third party, ex: fitness for duty physical exam. This Authorization is valid for ninety days from the current date and will expire at that time unless another date is clearly noted _____.

_____

Signature of patient or legal representative **First and Last Name - Printed** **Current Date** **Current Time**

As legal representative – relationship to patient is: _____ document proving such authority must be attached / included with this authorization form. Patient is unable to sign because: _____

NOTE: Fees may apply for provision of any or all requested information. Under most circumstances, the law permits up to thirty days for record requests to be processed. Records for treatment may be immediately faxed to the patient's healthcare provider when requested.

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