Springcrest Family Physicians, P.C.
Consent for Release of Medical Information

Patient Name_____Date of Birth_____

Address_____Phone_____

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

Physician **to release** records:

Name _____

Address _____

Phone _____

Fax _____

Physician/Person **to receive** records:

Name _____

Address _____

Phone _____

Fax _____

Medical information to be sent (check one):

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

☐ Entire medical record, ***including*** 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.

☐ Entire medical record, ***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.

☐ Record of care from _____ to _____ ***including*** 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.

☐ Record of care from _____ to _____ ***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.

☐ Other _____

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

This consent applies to all information in my medical record protected under the regulations in 42 CODE of Federal Regulation Part 2. I understand that if I release my medical record 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 until (date) _____; but that I may revoke my consent at anytime providing written consent to the above named party.

_____

Patient or Legal Guardian Signature Date

_____

Name of Legal Guardian Phone Number