Frontier Family Medicine

Board Certified

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REQUEST TO DISCLOSE MEDICAL RECORDS

Full Patient Name: _____

Date of Birth: _____ Telephone: _____

Purpose of disclosure: □ Continued Medical Care □ Personal Use □ Transfer
□ Surgery □ Other _____

Please disclose records from dates of _____ to _____. Pertinent records only.

□ All pertinent records for the last 6 months

□ Complete Medical Record □ Vaccinations □ X-ray
□ Progress Notes □ Laboratory/Pathology □ Billing
□ History/Physical □ EKG □ Other

By marking the following you are authorizing FFM to disclose types of ***super-confidential information*** as stated in the NOPP.

□ HIV records (including HIV test results) and sexually transmissible diseases
□ Alcohol and substance abuse diagnosis and treatment records
□ Psychotherapy records
□ Not applicable

Send To:
Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Fax Number: _____

Released From:
Name: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Fax Number: _____

I understand that this authorization includes disclosure of all medical records including psychiatric, alcohol and drug abuse records, and are protected by virtue of the provisions of Federal Regulations 42 C.F.R. Part 2. I make this authorization upon the promise that the following notice shall accompany all disclosures of alcohol and drug abuse records made pursuant to this authorization: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. I do hereby acknowledge that I have read, am familiar with and fully understand the terms and conditions of this authorization. We will not condition treatment or payment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by HIPAA of 1996. This authorization is to expire 12 months from the date of the signature unless revoked earlier in writing.

Patient/Guardian Signature **Date**

Witness **Date**