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| **Records Obtain Form**  **(Authorization to OBTAIN Protected Health Information)**  ***!!!*** |

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| ***PLEASE MAIL OR FAX RECORDS.  Accepted Forms:  Paper, Thumbdrives.  WE DO NOT ACCEPT CDs***  **PATIENT INFORMATION**   |  | | --- | | **First Name Last Name MI** | | **Date of Birth Social Security Number** | | **Street Address City State Zip Code** | | **Home Phone Number Cell Phone Number Work Phone Number**  **( ) - \_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_ ( ) - \_\_\_\_\_\_\_** |   **I authorize Berkeley Family Practice, LLC to OBTAIN my medical records FROM:**   |  | | --- | | **Name of Business / Person(s) / Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Street Address, City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Name of Business / Person(s) / Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Street Address, City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Name of Business / Person(s) / Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Street Address, City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |   **Information for Treatment Period:**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(Date)**                                             **(Date)**  **I authorize the release of the following Personal Health Information including but not limited to:**   * Patient Identification / Diagnosis List ● Radiology Films & Reports * EKG / Cardiovascular ● Physical Therapy Notes * Pathology Reports & Lab Tests ● Billing Information * Pulmonary Function Tests ● Occupational Therapy * Office Notes / Physical Dictation   **Please initial beside each item:**  \_\_\_\_\_ SENSITIVE INFORMATION: I understand that my record may include information relating to acquired immune-deficiency syndrome (AIDS) or  Human Immuno-Deficiency Infection, Psychological Assessment, Behavioral and/or Mental Health Services, Sexually Transmitted Diseases,  Alcohol and/or Drug Abuse and this information will be released.  \_\_\_\_\_ RE-DISCLOSURE:  I understand that any disclosure of information carries with the potential for re-disclosure and the information then may not  be protected by federal confidentiality rules.  \_\_\_\_\_ RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in  writing and that the revocation will not apply to information already released based on this information.  \_\_\_\_\_ EXPIRATION: : I understand that this authorization will expire 12 months after signed unless an earlier date is advised here.  \_\_\_\_\_ CHARGES: I understand that there may be a charge for releasing the requested information.  RecordQuest has been contacted to provide the  service and will bill you directly.  Questions may be directed to RecordQuest @ 888.300.7410.  **I HAVE READ THE ABOVE STATEMENTS AND POLICIES OF BERKELEY FAMILY PRACTICE, LLC AND BY SIGNING BELOW, ACKNOWLEDGE RECEIPT AND UNDERSTANDING OF THE SAME.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Patient or Legal Representative **Date**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Description of Legal Representative’s Authority (attach necessary documents) |