Sharonville Family Medicine

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Request/Release of Medical Records Form

Patient Name: ___________________________________ Date of Birth: ________________

Dependents:
Name: ___________________________________ Date of Birth: ________________
Name: ___________________________________ Date of Birth: ________________

From: ______________________________ To: ________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

Guardian Name (if patient under 18 years): ____

I hereby consent to the release of the listed information, including any alcohol, drug abuse, and/or mental health records obtained in the course of my diagnosis and treatment. I also authorize the release of HIV diagnosis or testing and sexually transmitted disease testing information, if applicable.

This authorization conforms with the regulations promulgated under Section 333 of the comprehensive Alcohol Abuse and Alcohol Prevention, Treatment, and Rehabilitation Act of 1970 and the section of the Drug Abuse Office Treatment Act of 1972.

Records obatined as authorized by this consent for informatin release will be maintained in accordance with federal regulations regarding confidentiality. Title 42 of the Federal Register prhobits re-disclosure.

Data Requested:

- □ 2 years of notes and medication record
- □ pertinent- EKG, labs, test results (CT/MRI/xray, etc…)
- □ other: ____

Reason for request:

- □ transfer of records
- □ other: ____

This authorization is valid for six months unless revoked in writing at an earlier date.

Signature: ________________________________ Date: ________________________

If signed by someone other than the patient(s) listed above:

Name: ____