Bent Tree Family Physicians

Board Certified Family Physicians

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Authorization for Medical Records Release

Patient Information

Name (Last, First Middle) _____ D.O.B. _____

Home Address _____ Home Phone # _____

City, State, Zip Code _____ Work Phone # _____

Information Released From:

Name of Clinic/Physician _____

Street Address _____

City, State, Zip Code _____

Phone Number (area code) _____

Fax Number (area code) _____

Information Released To:

Name of Clinic/Physician _____

Street Address _____

City, State, Zip Code _____

Phone Number (area code) _____

Fax Number (area code) _____

TYPE/ EXTENT OF RECORDS TO BE DISCLOSED: (CHECK ONE)

(Please note that a fee may be required with this service)

____**Records pertaining to:** _____
(Specific dates or conditions)

____**Entire patient records**

Purpose or need for disclosure: (check one)

_____Personal
_____Consult / Specialist
_____Selected a new physician
_____Moving out of town
_____Change of Insurance
_____Insurance Application

All records pertaining to mental health, chemical dependency, and/ or AIDS/ AIDS related illness will be released unless otherwise indicated in writing.

_____

_____

I hereby authorize release of my medical records. I understand that this release is valid for 90 days from date of signature, and that I may revoke this authorization in writing. I agree that any release made prior to this revocation will be made in compliance with this authorization. This information may be subject to re-disclosure by the recipient and is no longer protected by the privacy rule.

_____ _____

Patient Signature/ Legal Guardian Date