

Brown Road Family Medicine, PLLC

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MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone#: _____ Cell/Night #: _____

Please Check One Of The Below

_____ I hereby authorize Brown Road Family Medicine to release copies of any and all medical records to me.
(If it is more than 20 pages it will be on a CD)

_____ I hereby authorize Brown Road Family Medicine to release copies of any and all medical records to the Medical Office/Provider/Hospital listed below.

_____ I hereby authorize the Medical Office/Provider/Hospital listed below to release copies of any and all medical records to Brown Road Family Medicine listed above.

MEDICAL FACILITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Phone #: _____ Fax #: _____

Release the following described medical records only (SPECIFY TYPES AND DATES)

_____ **X-ray** _____ _____ **Laboratory** _____

_____ **EKG** _____ _____ **Progress Notes** _____

_____ **Other** _____ _____ **Any and All (past 1 year only)** _____

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This consent will expire in sixty (60) days after the signed date below. I may revoke this authorization at any time providing I notify Brown Road Family Medicine in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my right to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. health insurance plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

I HEREBY RELEASE BROWN ROAD FAMILY MEDICINE FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

Patient Signature _____ Date _____

Patient and / or Authorized Representative _____ Relationship to Patient _____