Osteopathic Healing Arts
Direct Primary Care • Family Medicine
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# Authorization to Release Health Information

Patient Name _____ Date of Birth _____

Full Address _____

Phone # _____ Email _____

**Choose <u>One</u> Option Below**:

*(address above)*

☐ *I authorize the release of my medical records to Osteopathic Healing Arts from the following doctor or clinic:*

Name _____ Phone # _____

Address _____ Fax # _____

☐ *I authorize Osteopathic Healing Arts to release my medical records to the following person, doctor, or clinic:*

Name _____ Phone # _____

Address _____ Fax # _____

**Records to be Released**:

| | | |
|---|---|---|
| ☐ Entire Record | ☐ Psychiatric | ☐ Drug/Alcohol Abuse |
| ☐ Clinic Notes | ☐ Consultations | ☐ Discharge Summary |
| ☐ Lab Reports | ☐ History & Physical | ☐ ER Reports |
| ☐ Operative/Pathology | ☐ HIV Antibody Report | ☐ Imaging Reports |

☐ Other _____

**Approx. Treatment Dates** _____ **Purpose** _____

**Please release my records via**: ☐ The Above Email ☐ The Above Fax ☐ I will pick up paper copies.

*I understand that my health record may include information related to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that this consent is valid for 90 days from the signature date. I can revoke this authorization at any time by giving written notice to Osteopathic Healing Arts, LLC. As a nonmember, I agree to pay $20 per patient Records Request.*

_____ _____

**Signature of Patient or Authorized Legal Guardian** **Date**

_____ _____

**Legal Representative's Relationship to Patient** **Witness**