PULMONARY & SLEEP GROUP

Medical Records Request

Authorization | Request for Release | Disclosure of Information

I hereby authorize Questcare Medical Clinic to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as human immunodeficiency virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), behavioral and mental health (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, and other information. I understand that this authorization is voluntary and I may refuse to sign it. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, i.e., insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Patient Name:	Date of Birth:	Social Security Number:
Date(s) of service (if known):		
Description of information to be released (check all that apply): ☐ All medical records ☐ Certain medical records (specify):_____ ☐ Other (describe):_____		
Description of the purpose of the use and/or disclosure:		
The health information described herein shall be released to: ☐ Patient ☐ Hospital ☐ Insurance Company ☐ Attorney ☐ Physician ☐ Other:_____		

Records shall be disclosed to:

Name:	Street Address:	City:	State:	Zip Code:

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____. Records of more than 30 pages may be placed on an encrypted disk or drive.
expiration event/date

I understand that I may revoke this authorization at any time by notifying Questcare Medical Clinic, in writing to the clinic's address, ATTN: Privacy Officer. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

X _____ _____

Signature of Patient or Patient's Representative — Date

[Attorney seeking records is not qualified to sign authorization.]

_____

Printed name of Patient's Representative

_____ or _____

Relationship to Patient — Legal Authority (attach supporting documentation)

Office Use Only – Record of Disclosure:

Date of Disclosure: _____ Completed by: _____ Title: _____

Method of Disclosure: ☐ Mail ☐ Fax ☐ Encrypted Disc/Drive ☐ Pick up ☐ Other: _____

Notes:

☐ Scanned to EMR on _____ Signature: _____ Date: _____