☐ URGENT (Date Needed By): _____

☐ ID Verified (Initial and Date): _____

☐ DONE/Ready to be Scanned

Account #: _____

Last Physical: _____

Request Date: _____

Records Request (Request of Information)

Patient name: _____ Date of birth: _____

Purpose of Request:

☐ Changing Providers ☐ Personal ☐ Legal ☐ Insurance ☐ Other:

I am requesting records for the date(s):

☐ ____/____/____ to ____/____/____ ☐ Date of last visit ☐ All Dates

The records I want to share are:

☐ All Records ☐ Immunization Records ☐ Well Visit or Sports Clearance

☐ For the Treatment of: _____ ☐ Other: _____

I specifically approve sharing the following information: (check all that apply):

☐ Drug Use ☐ Alcohol Use ☐ HIV/AIDS ☐ Behavioral Health

☐ **Send Records To:** **OR** ☐ **Request Records From:**

Name and/or Organization_____

Address: _____City _____State _____Zip_____

Phone: _____ Fax: _____ ☐ Will Pick Up (We will call when ready)

By signing below I allow the release of my medical records. I am choosing to make this request. If the organization I have allowed to get the information is not a health plan or health care provider they may not have to follow federal privacy rules to protect my information. I can cancel this authorization in writing at any time. The cancellation would not affect any information already shared. *I do not need to sign this form to get health care at Doctors Care*

Patient or Authorized Individual's Signature Date Telephone Number

Printed Name Relationship (if not signed by the Patient)

IMPORTANT WARNING: The documents in this request are for the use of the person or entity listed on this form. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED.