LOURDES MEDICAL ASSOCIATES

MEDICAL RECORDS REQUEST

Print Patient Name: _____ Today's Date: _____

Date of Birth: _____ SSN#: _____

I am the above patient and I authorize release of my medical records <u>FROM</u>:

Print Name of Physician / Facility	Physician / Facility Address		
Physician / Facility Phone	City	State	Zip
Physician / Facility FAX:	Name of contact at Practice		

<u>TO</u> the following individual or facility:

Print Name of Individual / Facility	Individual / Facility Address		
Individual / Facility Phone	City	State	Zip
Individual / Facility FAX	Name of contact at Practice		

Type of information / documentation you wish to have released:

☐ Face Sheet / Registration

☐ History and Physical

☐ Progress Note(s) – Dates of Service: _____

☐ Other: _____

_____

☐ EKG Results

☐ Medication List

☐ Lab/ X-rays / Slides / CDs

Reason for Request: ☐ On-going care ☐ Transfer care ☐ Other: _____

I understand that if my record contains sensitive information such as mental health information, drug and alcohol abuse information or IDV related information, separate authorizations will be required.

I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization, I must do so in writing and present my written revocation to Lourdes Medical Associates. I understand that my revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance carrier as the law provides my insurer the right to contest a claim under my policy.

Unless I specify otherwise, this authorization will expire in six (6) months from the date signed below. I understand that it is not necessary for me to sign this form in order to receive health care treatment.

_____ Date: _____

Signature of Patient or Legal Representative

_____

Relationship to Patient