



Treating You Like Family

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Authorization to Request Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

I authorize:

Facility/Dr./Name:	Address/Location:
Telephone/Fax Number:	

to disclose the following information to **Hampton Family Practice** from the medical records of:

Patient Name:	Date of Birth:
Telephone Number:	MRN #

Dates to be disclosed: _____

This authorization is effective for 1 year from the date of this release unless revoked in writing.

Information to be disclosed:

Previous PCP Medical Records

Please Include ONLY the following information unless otherwise specified.

Most Recent Wellness Exam, Office Visit, EKG, Labs, Bone Density, Mammogram, Colonoscopy, Immunization Record and Growth Chart

- Immunization Record Progress Notes
- Laboratory Tests Diagnostic reports
- Consultation Reports Other _____
- Complete Medical Record

This information is to be released for the purpose of:

- Coordination of Care PCP Request
- Personal Legal Disclosure
- Leaving the Practice Insurance Change
- Other: _____

Hampton Family Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that information in my health record may include behavioral, mental health services or treatment for alcohol and drug abuse. I also understand my health record may include information regarding HIV, AIDS or other sexually transmitted diseases.

 Signature of Patient or Representative Date

 Print Name Relationship

Internal Use

Office Staff Signature: _____ **Date Request was Sent:** _____

As the person signing this consent, I understand I have the right to revoke this consent, but my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notification concerning the persons or agencies to which disclosure was made shall be included with original records. The person who received the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent, unless such recipient is a provider who makes a disclosure permitted by law.