MEDICAL RECORDS RELEASE FORM

DATE: _____

Please check one of the following options:

- ❑ I hereby authorize HovaCare Clinic to ***release*** the following information from the medical record(s) of:
- ❑ I hereby authorize HovaCare Clinic to ***request*** the following information from the medical record(s) of:

NAME_____ Date of Birth_____
ADDRESS_____
CITY _____ STATE_____ ZIP_____
PHONE NUMBER _____SOCIAL SECURITY NUMBER _____
Information to be released: **ALL** or Specific Dates_____
_____Office Visit notes
_____Laboratory test results/Imaging studies report/Immunization Records
_____Other-Please List _____
Purpose of Disclosure:
___ Continued Patient Care
___ Personal Use
___ Commercial Insurance
___ Other (Specify)
Records are to be:

- ❑ Requested from
- ❑ Sent to

NAME_____
COMPANY_____
ADDRESS_____
CITY_____STATE_____ZIP_____
PHONE _____ FAX _____

I understand that such medical records may contain information regarding psychological, drug, and /or alcohol conditions, and /or diagnosis, treatment and care of sexually transmitted diseases or complications related to sexually transmitted diseases, including but not limited to HIV testing and results. I hereby authorize the release of such medical records pursuant to this authorization for release or request of medical records, and waiver confidentiality provisions pertaining to this release. I understand letters, correspondences, and copies of medical records from other health care providers will not be released.
Specification of the date, event, or condition upon which this consent expires: I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereof. Request for revocation of this authorization must be in writing to HovaCare Clinic. This authorization will remain until terminated in writing.
The employees and physicians are hereby released from any legal responsibility or liability for the release or request of the above information to the extent indicated and authorized herein. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected under Title 45, CFR. HovaCare Clinic may not condition treatment or payment on whether you sign this authorization. I understand that authorizing this disclosure of health information is voluntary.

Signature of Patient_____ Date_____

Signature of Parent/Legal Guardian_____ Date_____

If Legal Representative, State Relationship_____

Patient Unable to Sign Reason_____ Witnessed _____Date_____