Medical Records Release

Patient Information *(please print clearly)*:

_____ _____

Last Name *First Name* *Middle Initial* *Date of Birth* *(Month/Day/Year)*

_____ _____

Street Address *Apt #/P.O. Box # (Please include complete mailing address)* *Medical Record Number/SSN*

_____ _____

City *State* *Zip Code* *Primary Contact Number*

I authorize Articularis Healthcare to disclose the above-named individual's health information to:

☐ Another Facility:

_____

Name

_____

Street Address

_____

City *State* *Zip Code*

☐ I would like to pick up my records in person.

☐ I authorize _____ to pick up my medical records in person.

(Name of person authorized to receive the record)

The information to be disclosed:

☐ All Billing Records

☐ Complete Medical Record

OR

☐ Partial Medical Record *(please specify records below)*

Information	Dates
☐ Office Notes	_____
☐ Lab Results	_____
☐ X-Rays	_____
☐ Other	_____

The purpose of the disclosure:

☐ My personal records ☐ Disability

☐ Attorney ☐ Other _____

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee is $0.65 per page for the first 30 pages and $0.50 for each page after 30.

I authorize Articularis Healthcare to obtain the above-named individual's health information on their behalf from:

_____
Name

_____
Street Address

_____
City *State* *Zip Code*

Information to be obtained*:

☐ Referral ☐ Clinical notes ☐ Recent labs and imaging reports ☐ Demographics
☐ All of the Above ☐ Other: _____

*Please fax information above to our Medical Records department at (404)-528-1858.
If you have questions, please call (678)-510-1805.

Expiration of Authorization:

Unless I request in writing otherwise, this authorization will expire on _____. If I do not specify an expiration date or (insert date or event) event, this authorization will expire ninety (90) days from the date on which it was signed.

Right to Revoke Authorization:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to Articularis Healthcare. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

Refusal to Authorize Use and/or Disclosure:

I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment

Re-Disclosure

I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

Release and Waiver

If the health information that I have requested Articularis Healthcare to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Articularis Healthcare from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

_____ _____
Signature of Patient or Patient's Legal Representative *Month/Day/Year*

_____
Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED, AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD