MEDICAL RECORDS RELEASE AUTHORIZATION

To: Dr. _____ Phone _____ Fax _____

Pursuant to my rights under HIPAA, I hereby request a copy of my medical records as a matter of urgency, and hereby authorize you to furnish full and complete records prepared or obtained by you within the last 24 months, preferably via fax: attention to my Doctor:

From: Dr. _____
Chronic Care Consultants
Attention: Medical Records
1-585-486-1440 (fax)
1-866-647-4284 (phone)

Medical records should include any and all medical information, including but not limited to MRI, x-ray, lab work, diagnosis, evaluation, EEG, EKG, physical exam, and treatment or assessment notes. For purposes of this authorization, medical information specifically includes any confidential information regarding presence of HIV/AIDS, drug or alcohol abuse, disease, or mental health status.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it may have an affect on any actions taken prior to receiving the revocation.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I have kept a copy of this form after I signed it.
7. The purpose for the release of these records is healthcare-related.

I have read and hereby authorize the release of the protected health information. This Authorization is valid for one (1) year from the date set forth below.

Please fax these records to Chronic Care Consultants as indicated above.

_____/____/_____
Printed Name of Patient Date Phone #

_____
Patient SS#

_____/____/_____
Patient Signature D.O.B. Email