Manhattan Medical Group

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Authorization to Release/Request for an Individual's Health Information/Treatment Records

Last Name	First Name	Middle
Street Address		Date of Birth
City, State, Zip		Phone
Other Names Used		

I hereby request access to the protected health information in my health record from (date) _____ to (date) _____ maintained or created by the provider named below to the recipient named below.

____ Most recent progress notes
____ X-ray reports
____ Billing records
____ Entire health record
____ Pathology/lab reports
____ Health summary
____ Immunization records
____ Other _____

_____

____ I will pick up copies of my records
____ Mail copies of my records to the individual noted below
____ Fax my records to _____
____ Provide my records in electronic form _____

_____

Records from	Records to
Name	Name
Street Address	Street Address
City, State, Zip	City, State, Zip
Phone	Phone
Fax	Fax

Purpose of Request: _____ Patient Request _____ Transfer _____ Continuation of care
_____ Other _____

I understand:

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present to my written revocation to Manhattan Medical Group staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I specify differently, this authorization will expire within 6 months from the date on which it was signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.

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

I authorize the above organization to disclose the above named individual's health information as described above.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness Date