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Request for Release of Medical Records
**** PLEASE PRINT ****

Records From:

MD or Group Name

Mailing Address

City, State, & Zip Code

Records To:

Moscow Family Medicine, P.A.
MD or Group Name

623 S Main Street
Mailing Address

Moscow, ID 83843
City, State, & Zip Code

Patient Information:

Name: _____
Other (maiden) name: _____
Birth date: _____ SSN#: _____

I hereby request and authorize the release of requested health care information from the above-named party to the corresponding above-named party. This authorization will expire one year from the date signed below, unless I revoke it earlier. I can revoke it by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to re-disclosure by the recipient. The information that I request to be released is:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> RECORDS FROM THE PREVIOUS 2 YEARS | <input type="checkbox"/> All Records | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Progress Notes Only | <input type="checkbox"/> History & Physical Exam Notes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Imaging Reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> AIDS/HIV/STD Information | <input type="checkbox"/> Psychotherapy notes _____
<small>Initial</small> | |

The time period of records I request to be released includes:

- ALL DATES From _____ to _____

I authorize the release of information as described above. I understand that there may be a charge for this service, and I agree to pay said charge on demand. This authorization will expire one year from the date signed below, unless I revoke it earlier. I can revoke it by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

Patient or Guardian

Date

If guardian, relationship

Minor Aged 14-17

If the patient is aged 14 years or older, only the patient may authorize release and/or disclosure of information related to sexually transmitted disease. I understand that my signature below authorizes release of this information. Authorization is valid for 1 year unless revoked earlier, and I can revoke this authorization by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

Patient

Date