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moukdad MEDICAL

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AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

This form authorizes the release or request of your medical records in accordance with federal and state privacy laws (HIPAA). Please complete to specify where records should be sent or obtained.

Patient Name: _____ **Date of Birth:** _____

Please select one or both:
☐ **OBTAIN** records *from* the provider listed below ☐ **RELEASE** records *to* the provider listed below

PURPOSE OF REQUEST

☐ Continuity of care ☐ Insurance ☐ Transfer of care to new provider
☐ Personal use ☐ Legal ☐ Other: _____

PROVIDER / FACILITY INFORMATION

Name of Provider or Facility: _____

Address: _____

Phone: _____ **Fax:** _____

INFORMATION TO BE RELEASED OR OBTAINED

☐ Complete medical record ☐ Lab results / imaging reports ☐ Immunization record
☐ Office visit notes ☐ Medication list ☐ Other: _____

Date Range (if applicable) From: _____ To: _____

AUTHORIZATION VALIDITY

This authorization will remain in effect for **one year** from the date of signature unless otherwise specified. I understand that I may revoke this authorization at any time by providing written notice to Moukdad Medical, except to the extent that records have already been released. I understand that once information is disclosed, it may no longer be protected under federal privacy law.

Patient Signature (or Legal Representative)**:** _____ **Date:** _____

If signed by Legal Representative, state relationship to patient: _____

FOR OFFICE USE ONLY

☐ **Request faxed on:** _____ **Staff initials:** _____
☐ **Records received on:** _____ **Staff initials:** _____