MERIDIAN PRIMARY CARE

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AUTHORIZATION FOR MEDICAL RECORDS RELEASE

By signing this form, I, ____Date of birth:______/_____/______
PATIENT NAME (printed)

AUTHORIZE : ____AT
(Prior Provider / Specialist / Hospital / Entity)

ADDRESS:____ CITY:_____________STATE:_____ZIP:_______

PHONE: (________) _________ -- _____________ FAX: (________) __________ --________________

to release confidential health information about me, by releasing a copy of my medical records or a summary of my protected health information, TO MERIDIAN PRIMARY CARE (Dr. Gopez/Dr. Lee/ NP Benner) at the above contact information. I understand that I am responsible for any fees for copying and mailing the information requested.

The information you may release subject to this release form is as follows:

☐ **Complete Records** ☐ Other:____

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SPECIAL AUTHORIZATION FOR DRUG / ALCOHOL/ PSYCHIATRIC TREATMENT RECORDS:

☐ I specifically authorize the disclosure of information pertaining to drug / alcohol /and or psychiatric treatment __________(INITIALS)

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Or

☐ Medication Records ☐ Operative Reports ☐ History and Physical

☐ Hospital Records ☐ Pathology / Cytology Reports ☐ Specific Dates:

☐ Lab reports ☐ Radiology Reports ___/___/____through___/___/____

The purpose of this release of information is for continuity of care (OR other: _________________________)

PATIENT NAME (Printed):_________________________________DATE OF BIRTH:_____/____/_____

STREET ADDRESS:____

CITY:____STATE:______________ZIP:______________________

PREFERRED CONTACT PHONE NUMBER: (______) _____________ -- __________________

SIGNATURE:____DATE:_________________
(Patient or Personal representative / Parent if patient is a minor / Guardian)

NAME OF REPRESENTATIVE / PARENT / GUARDIAN (printed):____

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY:____

Rev 5/2022