 **BELLBROOK FAMILY PRACTICE**

**Authorization to Transfer Records**

**I hereby authorize:**

Doctors Name/Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

To release any information in the below named patient(s) medical record, with no limitations. This authorization includes release of information for psychiatric/psychological illness, alcohol and/or drug abuse, drug related conditions, alcoholism, HIV test results and/or diagnosis/treatment of HIV/AIDS or related condition.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Patient Name Date of Birth Signature Patient/Guardian Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Patient Name Date of Birth Signature Patient/Guardian Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Patient Name Date of Birth Signature Patient/Guardian Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Patient Name Date of Birth Signature Patient/Guardian Date**

The following information is to be sent to the address below (please check the line below):

\_\_\_\_\_ Copy Entire Record \_\_\_\_\_ Operative Report(s)

\_\_\_\_\_ Face Sheet/Demographics \_\_\_\_\_ Consult/Progress Note(s)

\_\_\_\_\_ History and Physical \_\_\_\_\_ Other (please specify)

\_\_\_\_\_ Emergency Department Record(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Laboratory/Pathology/Radiology Report(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information is to be released to:**

Doctors Name/Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

A photocopy of this authorization is to be accepted the same as the original. This consent expires sixty (60) days from the date of signature and is subject to revocation by the patient any time prior to the expiration date except to the extent that action has been taken.

I hereby state that I have read and fully understand the above statements as they apply to the above-named patients(s). I hereby consent to the release of medical information with my signature(s) above.

Any further disclosure of this information is prohibited unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or a permitted by law.