Authorization to Obtain/Release Medical Records

Please note that this is a legal document and will not be honored unless it is completed in full.

Patient Name ______________________ SSN (optional) ______________________ DOB ______________________

I authorize the staff of Starling Physicians, PC to **Obtain/Release** my protected health information (PHI) as described below from my medical record to be used **for the purpose of** (any other use is prohibited). Check option below:

☐ Transfer of Care ☐ Second Opinion ☐ Relocation ☐ Other ______________________

FROM/TO: (name and address of person and/or entity information is to be obtained/released to (one recipient per release)

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The records information to be obtained/released shall include: (check the appropriate boxes)

☐ Entire medical record, including all information records pertaining to medical, psychiatric, other health related information, and information/records received from other health care providers. Psychotherapy notes will not be included, as they must be requested on a separate authorization form.

☐ Include only the following specified information/records from the medical record:

☐ History & Physical ☐ Operative Reports ☐ Pathology Reports ☐ Consultations ☐ Progress Notes
☐ PT/OT/ST Notes ☐ Laboratory Results ☐ Radiology Reports ☐ Radiology Films ☐ Billing Records
☐ Psychotherapy Notes (If this box is checked, no other information may be requested in the Authorization)
☐ Other ______________________ (please specify)

I understand that state law prohibits the use and/or disclosure of the following types of PHI below, unless specifically authorized. This information will not be disclosed unless I indicate by initialing below:

☐ Genetic Testing ☐ Psychiatric Information ☐ HIV (AIDS) related information
☐ Drug and/or alcohol abuse treatment information ☐ Sexual transmitted disease information
☐ Sexual abuse/assault and domestic violence records ☐ Mental health records

Dates of treatment covered by this release: (check only one)

☐ All dates
☐ Limited to the following dates/departments: ______________________

I understand that:

- This permission form is only good for one year from the date I sign it.
- I may cancel my permission at any time. I need to write you a letter to cancel permission. I need to bring or mail this letter to Starling Physicians, PC at ______________________. I understand that Starling Physicians, PC may send my records before I cancel this permission. There is nothing that can be done about that.
- I do not need to sign this permission form to get medical treatment.
- I am allowed to look at my medical records or to get a copy of my medical records before they are sent. The person who received my records may not be required to protect my information and may share my information with others without my permission.
- I will be charged a copy fee of .65¢ per page.

______________________ ______________________
Patient Signature or Legal Representative (must supply proof of Conservatorship) Date

______________________ ______________________
Witness Date

If signed by the Legal Representative, please indicate your relationship to the patient.

☐ Parent ☐ Guardian ☐ Conservator
☐ Executor of Estate ☐ Power of Attorney
☐ Other ______________________

Cancellation of Authorization:

______________________ ______________________
Patient Signature Date