



**PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS**

I, \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name

SS# \_\_\_\_\_

Patient Address

authorize \_\_\_\_\_

Name of Physician, Practice, Facility, etc.

to provide \_\_\_\_\_

Name of Physician, Practice, Facility, etc.

\_\_\_\_\_

Address of Physician, Practice, Facility, etc.

The information to be released is (state specific documents, time period, etc.):

Purpose or need for the information requested:

Continued Care \_\_\_\_\_ Insurance \_\_\_\_\_ Legal \_\_\_\_\_ Transfer \_\_\_\_\_ Personal \_\_\_\_\_

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

\_\_\_\_\_  
Patient/Parent/Legal Guardian Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

If signed by other than patient, state relationship and reason for patient's inability to sign.

A copy of this authorization has been \_\_\_\_\_ accepted \_\_\_\_\_ rejected by the patient/representative.

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

**Office Use Only:**

Please read these instructions carefully before completing the BMA Patient Authorization to Release Medical Records Form:

**Patient Name:** Patient Name used at time of care (maiden, married, etc.)

**Patient Date of Birth:** Complete: month- day – year

**Social Security #:** Complete: all 9 digits ex: 000-00-0000

**Patient Address:** Complete current address: House #, RR #, Box #, Street, City, State, Zip Code

**Authorize:** Complete name of physician, facility, address, zip code of where the record is currently housed.

**To Provide:** Complete name of physician, facility, company, person, etc., address, zip code of where you want the records sent.

**Information to be released/requested:** State specific time periods, documents, etc. Example: All office notes 6-1-06 through present, x-ray/pathology/lab & diagnostic reports from 6-1-06 through 6-1-07, MRI report done 6-1-06, etc. If specific dates/times are not requested, we will send last year of office visits, 6 months of lab reports (from last lab done) and 5 years of diagnostic reports. **We do not honor blanket authorizations for “any and all medical records”.**

**Purpose or need for the information request:** Please place a mark beside one of the five categories listed. Example: If records are for an appointment with a specialist you will mark “Continued Care”. If you are no longer a patient of BMA and want your records forwarded to another physician, please mark “Transfer”.

**Consent:** Please read complete statement before signing

**Patient Signature/Relationship/Date:** Patient/guardian/representative full name, if signed by patient, “self” will be the relationship. If signed by someone other than the patient, state relationship to patient: guardian/representative, etc. A valid authorization must be dated. If signed by other than patient, state relationship and reason for the patient’s inability to sign in space available toward the bottom of the form.

**Witness Signature/Date:** Complete name of witness and date witnessed.

*If you wish to receive copy of this authorization, please indicate by placing a mark next to “**accepted**” in the last statement of this form.*

We hope that these instructions will be beneficial in helping our patients complete this form. If you have any questions, please call 814-946-1655, select option 4 for “other” and then option 4 for “records and forms”. Thank you for your assistance in this effort.