BALD EAGLE
FAMILY MEDICINE

MEDICAL RECORDS REQUEST FORM

Medical Records Request Form All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

_____ _____ _____

Patient's Name | Date of Birth | Social Security Number

I authorize the use and disclosure of health information about me as described below:

_____

Facility Authorized to Release my Health Information | Phone Number | Fax Number

Bald Eagle Family Medicine – Tony Hedges, DO *HIPAA Compliant Email: records@baldeaglefamilymedicine.com

Agency or Individual(s) Authorized to Receive my Health Information

201 E Pearl Street, Suite B204, Granbury, TX 76048 (682) 205-1079 (682) 214-3222

Address: City, State, Zip | Telephone Number | Fax Number

Health information that may be used/disclosed is limited to the following:
O Progress Notes O History & Physical O Operative Note(s) O Emergency Room Report O Consultation(s)
O Imaging/X-ray O Lab O Discharge Summary O Pathology Report O Entire Record O Other (specify)

_____

Health information that may be used/disclosed is limited to the following treatment dates:

_____

Health information to be released to the above-named agency/individual is to be used/disclosed for the following purpose(s): Continuation of Care or document needed for patient's medical record

"Health Information" identifies you (the patient) by name and includes other demographic information about you. Information may include, but is not limited to medical records, x-ray films, slides, tracings, strips, etc. I hereby discharge the releasing facility, its agents, and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility. If applicable, I agree to the release of my medical or billing records containing the sensitive information listed above. Protected Health Information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply. This authorization will automatically expire 90 days after the date of signature below
(except as indicated above), unless an earlier date is specified, or at the conclusion of the specified event. I understand that I have a right to revoke this authorization at any time; in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.
NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Information Portability and Accountability Act (HIPAA) privacy regulations.

_____ _____

Patient or Authorized Representative Signature | Date Time

_____ _____ _____

Relationship to Patient | Witness's Signature | Expiration Date