

TRANSCEND MEDICAL GROUP

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MEDICAL RECORD RELEASE REQUEST

PATIENT NAME: _____
last first middle

ADDRESS: _____

city state zip

SOCIAL SECURITY # _____ SEX: M F DATE OF BIRTH: _____

HOME # _____ CELL # _____ WORK # _____

The following person or facility is authorized to provide copies of the patient's identifiable health information:

RELEASE FORM: NAME: _____

ADDRESS: _____
city, state, zip code

PHONE # _____ FAX # _____

SEND TO: NAME: _____

ADDRESS: _____
city, state, zip code

PHONE # _____ FAX # _____

PURPOSE FOR RELEASING THE INFORMATION:

Moving Away from Area Transfer of Care At Request of Patient For Patient Care

DESCRIBE THE INFORMATION THAT IS TO BE RELEASED:

Office / Treatment Notes Lab Reports X-Ray / CT Reports / MRI / Ultrasound EKG

Other: _____

INDICATE THE DATES OF SERVICE THAT IS TO BE RELEASED:

Entire medical records for services rendered at this office. Last office visit, laboratory and / or x-ray test results

Other (please specify): _____

I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record. I understand that if the person or facility receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Note: The revocation may be in writing and delivered to the above address of the person / entity of whom was to release information. I understand that unless earlier revoked, this authorization will expire 30 days after the date signed. I understand that there may be a charge for obtaining the requested information. Related charges can be obtained by contacting the medical records department. I understand that I have the right to obtain a copy of this authorization.

SIGNATURE _____ DATE: _____

Or Legal Representative of Patient: _____ DATE: _____
Attach Legal Representative Document

WITNESS: _____ DATE: _____

(OFFICE USE : DATE RECORDS SENT: _____ BY: _____