Legacy Family Medicine
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Authorization to Release/ Obtain Health Information

This form is to release your PHI as required by Federal and state privacy laws.

Permission to send Medical records to:
Request Medical Records from:

Patient's Name:	DOB:

I hereby authorize Legacy Family Medicine to obtain my Protected Health Information from the following organization(s) and/or person(s):

Doctor or Facility name: ____

Address: ____

Phone: ______________________ Fax: ______________________

I authorize the following information to be obtained:
Any and all information pertaining to ____________ appointment(s) including current labs, radiology reports and last office visits.

*Note: State law requires that you give specific permission to release the information below even if listed on the lines above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply:

Genetic Information: _____
HIV/AIDS: ______
Substance/Alcohol abuse: ______
Mental/Behavioral Health: ______
Purpose of Release: Primary Care Records

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Privacy Officer. I am aware that my revocation is not effective to the extent that the persons I have authorized to use an/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Legacy Family Medicine may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as the original release. If I authorize Legacy Family Medicine to fax information, I realize there are inherent risks in faxing PHI, I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing PHI released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

Signature: ____ Date: _______