primarycare
HEALTH PARTNERS

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Patient Name:_____ DOB:_____

Address:_____

City/Town:_____State:_____Zip Code:_____

Phone:_____

I give Permission for _____to obtain records from:

Practice Name:_____Phone:_____

Practice Address:_____

City/Town:_____State:_____Zip Code:_____

Indicate Requested Records to be Sent:

☐ ALL

☐ Partial or Specific Records regarding:_____

From Date:_____To Date:_____

I understand that:

1. I may inspect or copy the protected health information to be used or disclosed.
2. I may revoke this authorization in writing by contacting your office, attention Administrator.
3. Information used or disclosed pursuant to the authorization may be subjected to re-disclosure by the recipient and no longer be protected by the HIPAA.

Patient Name:_____

Signature:_____Date:_____

Relationship to the patient (if signed by personal representative of patient):_____