



BOWLING GREEN FAMILY PHYSICIANS

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RECORDS RELEASE/ TRANSFER FORM

Patient Name: _____

Address: _____ Date of Birth: _____

_____ Phone Number: _____

I authorize the custodian of records of the above named to release/transfer the following information* (**check all applicable**):

- All records (Last 2 years will be released unless otherwise indicated) _____
- Progress Notes Last **2 years**
- Laboratory/pathology records **Last 3 Years**
- Other (describe specifically) _____
- Consultation Notes All **NOTES**
- X-ray/radiology/ EKG's: **Last 5 Years**
- Immunization record

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, Drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Physician/ Organization to RELEASE information Name: _____ Address: _____ _____ Phone: _____ Fax: _____	Physician/Organization to RECEIVE information Name: _____ Address: _____ _____ Phone: _____ Fax: _____
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The information may be used/disclosed for each of the following purposes:

- At my request (only the patient can check this box)
- For my health care provider
- For payment/insurance
- For employment purposes
- Other: _____

I would like the records to be delivered via (check one)

- I will personally pick up records
- Mailed to above address
- Faxed: _____

Note: There may be a fee for release of records; records will be released once payment is received.

This authorization shall expire in 1 year from the date of signature and may be revoked at any time.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of Patient or representative Date

Relationship to Patient

Printed name of Patient and or Representative

Witness

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to Bowling Green Family Physicians, 1215 Ridgewood Drive, Bowling Green OH 43402