Apex MD

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____Date of Birth: _____/_____/_____
mm dd yyyy

Phone _____ Email: _____

Legal Guardian name: _____ Relationship to Patient: _____

I request a copy or summary of the following medical records:

☐ Complete Medical Record***** ☐ Immunization Record***** ☐ Lab Report(s) ☐ X-ray Reports
☐ Electrocardiogram ☐ Allergy Records ☐ Surgical Procedures ☐ Other _____

****Required if transferring records to Apex MD***

****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.*

For dates of service from ____/____/____ to ____/____/____

Purpose of Release:

☐ Transfer of care ☐ Moving out of area ☐ Specialist consultation ☐ Legal ☐ Personal
☐ Insurance Claim ☐ Workers' Compensation Claim ☐ Pharmacy/prescription records/Other
_____

Release of Records: (Select one)

☐ Request to transfer records **TO Apex MD** from the office listed below

☐ Request to transfer records **FROM Apex MD** to the office listed below will incur a $25 Processing Fee

- Please allow 15 days for processing. Incomplete information will delay processing.

Office Name: _____

Address: _____

Phone: _____ Fax: _____

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.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that such a revocation will not apply to information that has already been released in response to this authorization.

Signature: _____
Patient or Legal Guardian