Storm CLINIC

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MEDICAL RECORDS RELEASE FORM

Today's Date: _____
(this form will expire in 1 year from date)

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY _____ STATE _____

ZIP CODE _____ PHONE NUMBER _____ CELL NUMBER _____

NAME OF PERSON REQUESTING RECORDS:

NAME _____Dr. Jeremy Storm, DO_____ RELATIONSHIP TO PATIENT: ___Infectious Disease Specialist/Internal Med___

RECORDS TO BE **SENT FROM**:

NAME: _____ FACILITY _____

ADDRESS: _____ CITY/STATE/ZIPCODE _____

PHONE NUMBER: _____ FAX NUMBER: _____

RECORDS TO BE **SENT TO**:

NAME: _____ FACILITY _____

ADDRESS: _____ CITY/STATE/ZIP CODE _____

PHONE _____ FAX_____

WHAT INFORMATION IS NEEDED FOR RECORDS REQUEST. PLEASE CHECK THE APPROPRIATE BOXES

- Dictation / Notes — Other: _____
- Labs
- Microbiology
- Imaging Tests — Other: _____
- Operative Reports — **Additional Notes from Requesting Facility**: _____
- Radiology Reports — _____
- Medication Lists
- Progress Notes — **Information will be disclosed because of:** Transferring care ___
- Consult Notes — Referral to Specialist _____ Legal Issues _____ Patient Request _____
- Cultures with Sensitivities and Micro

My Signature is approval of my authorization. I authorize the above named Physician and Medical Practice to release my protected health information to those identified on this release. I understand that if any person receives this information that is not covered by the federal privacy regulation, the release may no longer be protected. I understand that my health record may include sensitive and detailed related to STD's, AIDS, HIV, or mental health services and treatment programs.

Signature of Patient _____ **Date** _____