GOLDEN primary care

RECORDS RELEASE FORM

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

Date_____

Patient Name_____

Date of Birth_____

Current Provider & Practice

For purpose of transferring care, please release my medical records from your practice to:

Golden Primary Care
915 Seton Drive
Cumberland, MD 21502
Phone: (240)503.1500 Fax: (240)503.1501
HIPAA-compliant email: records@goldenprimarycare.net

As applicable, please include last EKG tracing, cardiac stress test, ECHO, colonoscopy, mammogram, DEXA, lab reports, pathology reports, imaging reports, consultant notes, genetic testing, vaccination records, patient notes from the last two years and any other information that would generally be deemed important for the continuity of my care.

I consent to have all information released to Golden Primary Care, even if my record contains information pertaining to physical or sexual abuse, alcoholism, illicit drug use, sexually-transmitted infections, HIV/AIDS, pregnancy termination and/or mental health treatment.

I understand that HIPAA allows for the electronic conveyance of my medical record.
My preferred method of this information transfer is to the HIPAA-compliant email as noted above. As a last resort, my records may also be faxed to the number listed above in the case that your electronic health information system does not allow for a more efficient electronic conveyance of this information.

Patient signature _____

If patient is a minor, or otherwise unable to sign, their legal guardian or power of attorney may do so below.

Printed name of guardian/POA _____

Signature of guardian/POA _____