Tri County Internal Medicine, P.C.

Medical Records Release Authorization

Patient's Full Name: _____ **Date of Birth:**_____
(please print)

SSN: _____ **Phone Number:** _____

*By signing this authorization, I authorize **TRI COUNTY INTERNAL MEDICINE** to (send or receive) certain protected health information (PHI) (to or from):

_____ **SEND TO** *(name and address or person(s) sending records)*:
_____
_____
_____

_____ **RECEIVE FROM** *(name and address of person(s) sending records)*:
_____
_____
_____

Reason for request:
_____
_____
_____
_____

Information to be released:
_____ Complete Record
_____ Partial Record (please specify)
( ) Pertaining to specific condition
_____
_____
( ) for Dates: ____/____/_____
To: ____/____/_____
( ) Other (please specify) _____
_____

Exclusions:
_____ Do not send any information relating to AIDS, ARC, or HIV Information
_____ Do not send any information relating to Alcohol or Drug Abuse
_____ Do not send any information relating to Mental Health Disorders.

All information will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:
_____ 90 days unless I specify an earlier expiration date here: _____
_____ 1 year
_____ The period of time necessary to complete all transactions related to this request

*Please **READ**, **INITIAL**, and **SIGN** below:

* I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I do not have to sign this authorization in order to receive treatment from Tri County Internal Medicine, P.C. and that I may withdraw this request at any time._____
* I agree to pay all fees associated with this release as I have been informed. I understand all sections of this form must be completed before it can be processed. _____

_____ _____
Signature of Patient *(parent or guardian for minors)* **Date of Authorization**