

ASSOCIATES IN PRIMARY CARE MEDICINE, INC.

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Patients Name: _____ DOB: _____ Phone #: _____

Address: _____

I AUTHORIZE APCM TO:

Release my Medical Records to: _____
(Providers Name)

(Address)

Obtain my Medical Records from: _____
(Name of Organization)

(Address)

Check Confidential Information To Be Released or Obtained:

- | | |
|---|--|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> X-ray and Imaging Reports |
| <input type="checkbox"/> Most Recent History and Physical | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Progress Notes (Date) _____ |
| <input type="checkbox"/> Prenatal Visit | <input type="checkbox"/> All Records |
| <input type="checkbox"/> Other (Please Specify) _____ | |

THE PURPOSE OF THIS INFORMATION IS FOR: Transfer Continuity of Care Attorney
 Insurance Other _____

I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

I understand that authoring the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

TO THE EXTENT APPLICABLE, I UNDERSTAND THAT MY RECORD MAY CONTAIN INFORMATION THAT IS CONSIDERED SENSITIVE UNDER LAW. MY INITIALS BELOW INDICATE THAT I PERMIT INFORMATION OF THIS TYPE, IF IT EXISTS, TO BE RELEASED.

- _____ Alcohol and/or Drug Abuse/dependency/diagnosis/treatment/referral *
- _____ HIV test results/AIDS related information/(ARC) diagnosis and/or treatment
- _____ Diagnoses and/or treatment relating to other communicable diseases
- _____ Mental Health/diagnosis/treatment/referral

* This information has been disclosed to you from records protection by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this expressly permitted by written consent of the person whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

Signature of Patient

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness