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Patient's Name: _____ DOB: _____ Phone#: _____

Address: _____

I AUTHORIZE APCM TO:

☐ Release ☐Obtain My Medical Records

_____
(Name of Provider/Organization)

_____
(Address)

How do you wish to receive records? Pick up Mail Email **Email address:** _____

Check Confidential Information To Be Released or Obtained:

_____ Problem List
_____ Immunization Record
_____ Most Recent History and Physical
_____ Medication List
_____ Prenatal Visit
_____ Other (Please Specify) _____

_____ Laboratory Results
_____ X-Ray and Imaging Reports
_____ Consultation Reports
_____ Progress Notes (Date) _____
_____ All Records

THE PURPOSE OF THIS INFORMATION IS FOR:

☐ Transfer of Care ☐ Continuity of Care ☐ Attorney ☐ Insurance ☐ Other (Please Specify) _____

I understand that I have the right to revoke this authorization at any time. 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 authorizing 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 Confidential Rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure(s) of this expressly permitted written consent of the person whom it pertains to 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