Medical Records Release

Name: ____ Date of Birth: __________________________

Address: _____________________________________ City: ___________________ State: ____ Zip: _________

Home Phone: ___________________ Work Phone: _____________________ Cell Phone: __________________

Please transfer my records as follows:

FROM: _______________________________________ TO: Access Medical Clinic

____

____

*Records to be released (check all that apply):

☐ Annual exam & pap smear / prostate
☐ Labs / X-ray
☐ Birth control
☐ Abortion care
☐ All medical records
☐ Other: ___________________________________

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including HIV/AIDS testing or treatment), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked:

☐ Drug and/or alcohol abuse, diagnosis or treatment
☐ HIV/AIDS testing and/or treatment
☐ Psychiatric care and/or mental illness
☐ Confirmed STI test results and/or treatments

This consent may be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

Printed Name: ____________________________________ **Date: _____________________**

Signature: _______________________________________

Witness Printed Name: _____________________________ Date: _____________________

Witness Signature: ________________________________