Medical Release *Form*

Patient Information

Full Name _____ Date of Birth _____
Maiden Name Or other names Used _____
Social Security Number: XXX-XX- _ _ _ _ (last four digits)
Address: _____ City:_____ State_____ Zip_____

Release From

Hospital/Clinic Name _____
Address _____ City_____ State _____ Zip_____
Phone #_____ Fax # _____

Release To

Person/Company/Organization Name: Robert S. Wagenaar, MD PearlMed DPC
Address 2795 Enterprise Ave. Suite 5 **City:** Billings **State:** MT **Zip**:59102
Phone # 406-702-1111 **Fax : 406-321-5029**

Purpose

☐ Continuation of Care ☐ Legal ☐ Other (Specify)
☐ Insurance/WC ☐ Personal

Dates of information to be released

Date of Service from_____ through _____
Date of Service from_____ through _____

Information To be Released/Accessed

I would like copies of the items checked below for the treatment dates listed above.

☐ Emergency Report ☐ Operative Report ☐ Clinic Visit ☐ Discharge Summary ☐ Consultation ☐ Billing Records
☐ History Physical ☐ Laboratory ☐ Cardiac Studies/EKG ☐ ImagingCD/FILM (Mri/ct/Xray/Ultrasound) ☐ Imaging report ☐ Other:

Disclosure/Access Format

I would like copies of the items checked above in the following format: (Paper format-USmail is default if not marked)

☐ **Paper format - US MAIL** ☐ **Review Only** ☐ **Fax: (healthcare provider only)**
☐ **Paper format - PICK UP** ☐

Patient Access Information

- I will provide a picture ID prior to accessing my medical records.
- I may review my medical record without a charge. If I request copies of my medical record, I may be charged a fee.
- I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.

I Understand That

- The Information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care: sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and or alcohol abuse.
- *Without my express revocation, this authorization will automatically EXPIRE 180 days from the date signed below, unless I request an expiration date less than 180 days.*
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule, unless the disclose includes records from a federally-assisted program specifically providing diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case redisclosure is prohibited under 42 CFR Part 2.

My Signature is required to validate this authorization. If you do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided. According to State Statutes, this care site may charge for copies of medical records.

_____
***Signature** of Patient/Guardian/Personal Representative Relationship (if not patient) Date*

_____
Personal Representative's PRINTED Name, Address, and Phone number
If patient is unable to sign document (reason): _____

For Office Use Only

Date Authorization Received: _____ ***By:*** _____ ***Identification/Driver's License # Verified:*** _____
Date Request Completed: _____ ***By:*** _____ ***Delivery Instructions:*** _____

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direct.primary.care

PearlMed Direct Primary Care Authorization for Release/Disclosure of Protected (PHI)

Place Patient Label here: