GLOBAL CARE MEDICAL GROUP

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS

PATIENT'S NAME: _____ DATE OF BIRTH:_____ TEL NO:_____

ADRESS:_____CITY:_____STATE:_____ZIP:_____

I AUTHORIZE:_____
NAME OF PHYSICIAN, FACILITY OR PERSON

_____ _____ _____ _____
STREET CITY STATE ZIP

TO RELEASE PROTECTED HEALTH INFORMATION, CONTAINED IN THE MEDICAL RECORD OF THE ABOVE-NAMED TO THE FOLLOWING:

PROVIDER/FACILITY:_____

_____ _____ _____ _____
STREET CITY STATE ZIP

SENSITIVE HEALTH INFORMARTION:
If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. I understand and agree that this information will be sent to the provider at the location noted above UNLESS I place my initials in the applicable space next to the type of records:

___ MENTAL HEALTH TREATMENT RECORDS
___ GENETIC TESTING
___ HIV/AIDS TEST RESULTS
___ SEXUALLY TRANSMITTED DISEASE (STD) TREATMENT RECORDS
___ ALCOHOL/DRUG ABUSE TREATMENT RECORDS
___ DOMESTIC ABUSE

INFORMATION TO BE RELEASED: CHECK ALL THAT APPLY

DATES OF TREATMENT TO BE RELEASED: _____ TO _____

___ OFFICE NOTES ___ LABORATORY RESULTS ___ IMMUNIZATION RECORD

___ OTHER: _____ ___ COMPLETE RECORD ___ X-RAY (REPORTS ONLY)

PURPOSE OF RELEASE: ___ MEDICAL CARE ___ TRANSFERRING OUT OF PRATICE ___ OTHER: _____

I understand the once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not re-disclose my health information to a third party. Such third party may not be required to abide by this authorization or applicable federal and state law governing the use of and disclosure of my health information. I understand that I may refuse to sign or may revoke this authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment. I understand that this authorization will expire 90 days from the date of said unless I provide a written notice of revocation to the releasing facility noted above.

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

_____ _____
PRINTED NAME OF THE PATIENT OR AUTHORIZED REPRESENTATIVE RELATIONSHIP TO PATIENT