

# Falcon Health Center

838 E. Wooster St. ~ Bowling Green, OH 43402 ~ (P) 419.372.2271~ (F) 419.354.3222

## Records Release/Transfer Form

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

I authorize the custodian of records of the above named to release/transfer the following information (check all applicable): \*Note If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information

All records (Last 2 years will be released unless otherwise indicated) \_\_\_\_\_

Progress Notes Last 2 years

Consultation notes All Notes

Laboratory/Pathology records Last 3 Years

X-ray/radiology/EKG's Last 5 years

Other (describe specifically)

Immunization record

### Physician/Organization to **RELEASE** information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Physician/Organization to **RECEIVE** information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### The information may be used /disclosed for each of the following purposes:

At my request (only the patient can check this box)

For my health care provider

For Employment Purposes

For Payment/insurance

Other \_\_\_\_\_

### I would like the records to be delivered via (check one)

I will personally pick up records  Mailed to above address  Faxed: \_\_\_\_\_

This authorization shall expire in 1 year from the date of signature and may be revoked at any time. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Printed name of Patient and or Representative

\_\_\_\_\_  
Witness

You have the right to revoke this authorization, except to the extent the custodian of records has replied to it, by sending your written request to Falcon Health Center 838 E Wooster, Bowling Green, OH 43402