Falcon Health Center
838 E Wooster
Bowling Green Ohio 43402
Phone: 419-372-2271   Fax: 419-372-8010

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 (<u>check all applicable</u>): *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
__ Laboratory/Pathology records Last 3 Years
__ Other (describe specifically)
__ Consultation notes All Notes
__ X-ray/radiology/EKG's Last 5 years
__ Immunization record

Physician/Organization to ***<u>RELEASE</u>*** information

Name:____
Address:____
Phone:________________________________Fax:________________________________

Physician/Organization to ***<u>RECEIVE</u>*** 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 Payment/insurance
__ For Employment Purposes
__ 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 relied on it, by sending your written request to Falcon Health Center 838 E Wooster, Bowling Green, OH 43402