MEDICAL RECORDS REQUEST AND RELEASE

Patient Name: _____ DOB: _____ MR#: _____

Address: _____
City State Zip Code

I, the undersigned, hereby authorize _____
(Health Services Provider)

to provide from my medical record the information specified below to SPHC

for the purpose of Continuety of Care

I understand that the entire medical record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should not be released:

Last 6 mo. to include lab & Results also Medication list

Release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

This authorization shall be valid until _____
Date

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received ❑ Yes ❑ No

Patient's Signature: _____ Date: _____

or Personal Representative: _____

Request Received By: _____ Date: _____