HEALTHSOURCE MEDICAL CLINIC

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name_____

Address_____ City_____

State_____ Zip_____ Phone_____ DOB_____ SSN_____

Which records are needed: _____

Reason for transfer/request (Please check all that may apply)

___ Transferring Physicians
___ Referral for Continued Medical Care
___ Other _____
___ Insurance Requirements
___ Legal Action

I, the undersigned, do hereby authorize and direct you to

[ ] Provide records ***TO*** Health Source Medical Clinic from:

[ ] Release records ***FROM*** Health Source Medical Clinic to:

Name_____

Address_____ City_____

State_____ Zip_____ Phone_____ Fax_____

Check how records are to be received: ___ Mail ___ Pick-Up ___ Fax

***IMPORTANT NOTICE**: Per Health Source Medical Clinic's Policy, we only copy, print, or mail records. We **DO NOT** copy, print, mail, or fax other Doctor's medical records. Please contact your past Doctor for these records.

I understand that my request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I also understand that I am responsible for any additional cost for copies.

I UNDERSTAND THAT HEALTHSOURCE MEDICAL CLINIC DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS.

Signed by: _____ _____ _____
Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____
Print Patient's Name | Print Name of Legal Guardian, if applicable