PATIENT REQUEST FOR MEDICAL RECORDS TRANSFER
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

PATIENT NAME　　　DATE OF BIRTH　　/　　/

ADDRESS STREET　　　CITY　　　STATE　　ZIP CODE

I have been a patient of your office/facility (or am the patient's authorized representative) and I understand that the practice/facility provider has legally protected health information about me (or the person I represent) that I wish to transfer.

PROVIDER THAT HAS YOUR RECORDS

I, ______________________________ **hereby authorize the provider to release my records:**

PROVIDER NAME

ADDRESS STREET　　　CITY　　　STATE　　ZIP CODE

PHONE　　　FAX

PROVIDER YOU WANT TO RECEIVE YOUR RECORDS

PROVIDER NAME

ADDRESS STREET　　　CITY　　　STATE　　ZIP CODE

PHONE　　　FAX

Medical records to be release: ***(please check all that apply)***

- ☐ Entire medical record
- ☐ Operative Reports
- ☐ Radiology (x-ray, CT, MRI, etc.)
- ☐ Lab Results
- ☐ Emergency Department
- ☐ Outpatient/Clinic (specify)
- ☐ Other (specify): ______________________________

For treatment dates from ______________________ to ______________________.

- By signing below, I acknowledge that: I may revoke this authorization in writing, but it will not affect disclosures/transfers already in progress made with this authorization
- I may refuse to sign this authorization, and my treatment may not be conditioned on my signing of this form, unless the purpose of my treatment is disclosure to a third party (for example, a drug test for employment)
- I can receive a copy of this authorization upon request
- A photocopy or scanned image of this authorization may be used in lieu of the original
- I understand that recipients may not be subject to federal law and disclose information which I have authorized them to receive

Signature: ______________________________ Date: ______________

If signed by a personal representative of patient, print name and relationship to patient:

Name: ______________________________ Relationship: ______________

Please attach a copy of documentation of personal representation, e.g., Power of Attorney, Legal Guardianship.

Oswego Community Hopsital formerly located at 800 Barker Drive - Oswego, KS