OVP HEALTH CARE

REQUEST FOR MEDICAL RECORDS

Patient Name: _____

Patient DOB: _____

Patient SSN: _____

Any records filed under another name? _____

I authorize OVP HEALTH CARE to:

☐ Obtain from ☐ Electronic ☐ Verbal ☐ Written

Name of Person/Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Relationship to Patient: _____

The following information:

☐ Presence in treatment ☐ Progress in treatment ☐ Treatment plans

☐ Results of physical exam ☐ Medical history/current status ☐ Laboratory test results

☐ Aftercare recommendations ☐ Discharge planning ☐ Discharge summary

☐ Financial information ☐ Medical records ☐ Dental records

☐ Medication list ☐ Other (please specify): _____

The following information requires the initials of the Patient or Legal Guardian before information will be released:

_____ Psychiatric/Psychological Information (this does **not** include Psychotherapy Notes)

_____ AIDS/HIV Information

_____ Drug/Alcohol Information

_____ STD/Family Planning

Dates of Service being Requested: _____

Purpose or Need of Disclosure: _____

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 CFR Part 160 and subparts A through E of Part 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychosocial, drug or alcohol abuse, HIV/AIDS, and/or related conditions. I understand that I may revoke this authorization at any time upon written notice to OVP HEALTH CARE. I acknowledge that such revocation will not be effective if OVP HEALTH CARE has already acted in reliance upon this authorization. 42 CFR Part 2 prohibits the unauthorized re-disclosure of these records.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Signature of Parent of Legal Guardian: _____ Date: _____

Please send information to:

OVP HEALTH CARE Location: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This consent will be valid for 365 days from the date of the signature, unless revoked in writing or otherwise noted by the patient or legal guardian. The information has been disclosed to you from records protected by federal confidentiality rules (43 CFR part 2 and 42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person who it pertains to or as otherwise permitted by 43 CFR part 2 and 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.