Genesis HEALTHCARE

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PATIENT REQUEST FOR MEDICAL RECORDS

1. Authorization: I authorize disclosure of protected health information (PHI) as described below.

Name of Patient: _____

Telephone: (___) _____ Date of Birth: __/ __/ _____

2. Release Records To (Please specify if different from patient):

Name: _____

Address: _____

Telephone: (___) _____

3. Requested Records:

- ☐ Office Notes
- ☐ Operative/Procedure Reports
- ☐ Laboratory Results (Excluding HIV Test Results)
- ☐ Non-Genesis Healthcare Records (Lab results, Operative /Procedure Reports, History & Physical Reports)
- ☐ All Medical Records
- ☐ Other _____

4. Dates of Service: From: __/ __/ _____ To:__/ __/ _____

5. Use of Information:

- ☐ Continuing Care ☐ Personal ☐ Insurance Claim
- ☐ Other _____

6. Delivery Method:

- ☐ Pick up in office ☐ Fax to: _____
- ☐ Mail to: _____
- ☐ Send electronically to my Genesis Web Portal account. If you do not have a Genesis Web Portal account, please provide your e-mail address to set up one.

  E-mail Address: _____

PATIENT REQUEST FOR MEDICAL RECORDS (continued …)

7. **Consent/Authorization:** The information/records will be used for the following purpose: _____

   This authorization is:

   ☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

   ☐ Limited to the following medical information:

   _____

   I also consent to the specific release of the following records:

   Drug/Alcohol/Substance Abuse _____ (initials)

   HIV Diagnosis/Treatment _____ (initials)

   Psychiatric/Mental Health _____ (initials)

   Genetic Information _____ (initials)

   Tests for Antibodies to HIV _____ (initials)

8. **Authorization Expiration Date:**

   If none specified, authorization will expire one year from date of signature.

   Date: __/ __/ ____

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that my medical care will not be conditioned on whether I sign this authorization.

9. **Signature:**

   Patient or Legal Representative: _____

   Date: __/ __/ ____

   If signed by someone other than the patient, indicate relationship

   _____