



Genesis
HEALTHCARE

PATIENT REQUEST FOR MEDICAL RECORDS

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mygenesishealth.com

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
