

Record Release Form

In order to release or obtain your records, all of the following information must be provided.

If any information is left blank, your request **will not** be processed.

First Name	Last Name	Date of Birth / /	Today's Date
Address			
City		State	ZIP Code
Home Phone ()		Social Security Number	
Are you transferring out of our facility? <input type="checkbox"/> yes <input type="checkbox"/> no			

I authorize _____ to:	
<input type="checkbox"/> Obtain my records from or <input type="checkbox"/> Release my records to	
Facility Name	Doctor's Name
Address	
City	State ZIP Code
Phone ()	Fax ()

I hereby consent to the release of all medical records and other documentation pertaining to the medical care received in this facility, including the following: <input type="checkbox"/> All treatment <input type="checkbox"/> Lab reports/X-ray reports <input type="checkbox"/> Treatment related to specific injury or illness	Dates of treatment
	Beginning date _____
	Ending date _____

I understand that I am only obtaining the records produced by this facility and not the records that were forwarded to them from any previous primary care physicians. I specifically consent to the release of any information contained in the medical records that may relate to the infection with human immunodeficiency virus (HIV), AIDS, or related conditions, as well as information regarded as confidential.

I understand that CMCI has no responsibility for the use or distribution of this information by the party to whom it is released. I release CMCI from all liability that could arise from compliance with this request to release records. I authorize CMCI to transmit this information by facsimile transmission (fax) and/or mail and release CMCI from any liability for potential breach of confidentiality due to misdirection of transmission or failure to receive transmission of my records.

Signature of Patient or Responsible Party		
Signature	Print Name	Date
Witness	Print Name	Date