RELEASE OF MEDICAL RECORDS

PATIENT DETAILS

Patient Name: _____ Date of Birth: _____

Patient Address: _____

RELEASE OF MEDICAL RECORDS CONSENT

I **hereby authorize the release of my medical records from your facility (including medical claim information and/or clinical information) to:**

Partnership Health Centers

Please fax any and all medical records for the past year to your Partnership Health Center including but not limited to:

~History & Physical Notes
~Physicians/Nurses Office Notes
~Last Hospital Visit
~Bloodwork Results/Imaging Reports

Please provide practice name and contact info so that we may facilitate on your behalf:

Practice/Provider: _____

Address: _____

_____

Tel: _____ Fax: _____

I understand that these records will be used for the purpose of my health care, including care coordination services at Partnership Health Center.

Additionally, if applicable I am requesting the cooperation of all of my health care professionals in facilitating the coordination of my health care through the Care Coordination program. This record release consent will remain in effect for so long as I am employed by _____ and under the care of Partnership Health Center.

Signature: _____ Date: _____
(Parent/Guardian signature if under age 18)

Print Name: _____