Authorization for Release of Medical Records

Make your $25 records fee payable to Holistic Family Practice

Please print carefully. Forms not **FULLY** completed will **not** be processed. Fully completed forms that are not accompanied by the required $25 pre-payment fee check will **not** be processed.

______________________________	______________________________
Patient First and Last Name **Note:** Only one single patient per form.	Patient Email Address - **Required for Digital Downloads**
Current Mailing Address	Patient's Date of Birth via MM/DD/YYYY
City, State Zip Code	Patient's Telephone Number

HFP C/O Jonathan March, D.O. is authorized to release this patient's protected health information to:

____

Facility, or Practice Name (or Person's Name if not to a new PCP)

____

Street or PO Box City State Zip

____

Telephone Fax

1.The specific information to be disclosed: (**also** note digital download or CD if requesting records **to yourself**):

____

Note: Only one single format and one single recipient per form request.

SENSITIVE INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH should or should not be DISCLOSED. **Note:** A signature is **required here**, below, either on the YES **or** NO **signature line as required by HIPAA.**

YES, DISCLOSE THIS INFORMATION x____

or

NO, **DO NOT** DISCLOSE THIS INFORMATION x____

2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or the facility receiving it, and would then no longer be protected by federal privacy regulations.
3. I may revoke this authorization by notifying Holistic Family Practice, Inc. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. I understand that I am not required to sign this authorization in order to receive treatment or to enroll in or be eligible for medical benefits.

5. **The purpose of this request:**____

Above reason is **REQUIRED** (Transfer of of Care, Legal, Personal Copy, etc.)

This authorization **expires** on ____________________________, 20______, **OR** 90 days from the date signed.

FEES FOR COPIES: As of January 1st 2019, a pre-payment requirement of $25 **must accompany this form.** Make your check out to Holistic Family Practice. Email Dr. March at **JMARCH1@PARTNERS.ORG** for the postal address to mail the form and check to.

THIS FORM MUST BE FULLY COMPLETED and SHOW YOUR SIGNATURE BOTH IN STEP 1 and BELOW

X______________________________	________________	______________________
Signature of named Patient or, if under 18, the *Signature of Guardian, or *Signature of Legal Representative of Patient's Estate	**Date of Signature**	***If not the patient's signature, a description of the signer's Authority to Act**