Office Use Only - Account Number: _____ Effective July 1, 2019

FAMILY MEDICINE
SAMMY LERMA, III M.D., P.A.

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Authorization for Release of Medical Information
Medical Records Release Form

Patient Full Name (PRINT)_____
Address:_____
Telephone Number: _____Date of Birth_____

I hereby authorize Sammy Lerma III MD PA to release my Protected Health Information to the following designee by the selected delivery method:
SELECT ONE DELIVERY METHOD:
☐ **Pick up** records for patient (self) **OR**
☐ **Fax secure electronic copy** to: ☐ A doctor/hospital ☐ a third party (insurance company,attorney)
RECIPIENT: Name/Agency: _____
MAILING ADDRESS: _____
Fax number: _____ Phone number: _____

PLEASE CHECK SPECIFIC INFORMATION REQUESTED:

Dates of treatment: ☐ All dates OR ☐ Specific dates: from _____ to _____

I authorize the following information to be released:

☐ All Medical Records **OR**	☐ Abstract of record (Office Notes, Procedures, & Test Results Only)

OR CHECK SPECIFIC RECORDS

☐ Discharge Summary ☐ History & Physical ☐ Hospital/ER visit ☐ Images ☐ Immunizations	☐ Lab reports ☐ Medication List ☐ Surgical History ☐ Occupational Health Rec ☐ Pathology reports	☐ Physical Therapy Notes ☐ Physician Office Visits ☐ Progress Notes ☐ Radiology (x-ray) reports ☐ Other: (specify) _____

The purpose of the disclosure: ("Request of the Individual" is sufficient for patient-initiated releases)

Request of the Individual___	Change of Doctor _____	Legal purpose _____
Referral to Specialist _____	Insurance _____	Other: (specify) _____
Continuing Care _____	Workers' Comp _____	

CONDITIONS and NOTIFICATIONS:
State law allows a patient to obtain a copy of his/her records or ask that a copy be sent to other parties. Our office shall furnish the information within 15 business days after the date of the receipt of the request of records and payment of fees for furnishing the information directly to the patient. Patients will receive an estimate of the charges before making copies; the fee we charge is cost-based. Fees must be paid in advance of record release. There will be no charge for records sent directly to a provider for continuity of the patient's care. I hereby authorize the use or disclosure of the personal health information described above. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to disclosure.

EXPIRATION: This authorization will expire 180 (6 months) from the date of my signature, or specified as follows:
_____

Signature of Patient or Guardian _____ Date _____
Relationship to Patient (Self, Parent, Care Provider, etc.) _____