REQUEST TO FORWARD RECORDS

I, _____, hereby request and authorize
Patient

Original Doctor/Office Name: _____

Address: _____

Phone: _____

E-mail: _____

to discuss and provide copies of any and all clinical treatment records and information concerning my care (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services), which is in the possession of this person or entity to:

New Doctor/Office Name: _____

Address: _____

Phone: _____

E-mail: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic not telling us that your authorization is revoked.

When your health information is disclosed, as provide in this authorization, the recipient often has not legal duty to protect its confidentiality. In many cases, the recipient may redisclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOUSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____

Patient Signature Date