

PRIMARY CARE SPECIALISTS, INC.

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REQUEST FOR RELEASE OF MEDICAL RECORDS:

I hereby authorize the release of my medical records (to/from) Primary Care Specialists (to/from): _____

The medical records to be released may contain medical information pertaining to psychiatric, drug and/or alcohol, HIV/AIDS, diagnosis and treatment. I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason. I understand this authorization expires or I provide a written notice of revocation to the practice privacy officer at the above listed address.

Upon disclosure of my health information from Primary Care Specialists to the patient, Primary Care Specialists cannot guarantee the re-disclosed information to a third party. Any third party may not be subject to this authorization or applicable federal and state law governing the use and disclosure of my health information.

Authorization will remain in effect for 60 days unless otherwise indicated:

__ From the date of this authorization until _____

__ Until the following occurs _____

__ Other _____

Patient Name: _____

Patient Signature: _____

Date of Birth: _____

Social Security #: _____

Today's Date: _____