Ottawa Family Physicians
Authorization for Release of Medical Records

I authorize the following protected health information to be released from the medical record of

______________________	______________________	______________________
Last Name (Please Print)	First Name (Please Print)	DOB

____

Address (Street, City, State, Zip

______________________	______________________	______________________
(Phone Number)	(Cell phone Number)	Physician at OFP

Release Records **FROM**: ____________________________ Address:____________________________ City/State/Zip:_________________________ **Phone**: ____________________________ **Fax**:	**TO: Ottawa Family Physicians** 1418 S. Main, Suite 5 Ottawa, Ks 66067 Phone: 785-242-1620 FAX: 785-242-5061

OR

Release Records **TO:** ______________________________ Address:____________________________ City/ State/ Zip:_______________________ **Phone**: ____________________________ **Fax**:	**FROM: Ottawa Family Physicians** (Same As Above)

Purpose for the Release:

Transfer of Care:__________ (Choosing a new family physician)

Other:____ If not transferring, please state the reason for records release.

Information to Be Released:

_____ Physician Progress Notes	____ Cardiac Studies	____ History & Physical
_____ Radiology Reports	____ Consultation Reports	____ Discharge Summary
_____ Lab/Pathology	____ Emergency Room Records	____ Patient Demographic Info
_____ For Specialist Referral	____ Operative Procedure Notes	____ Billing
_____ Other:		

____All Records from the Past 3-5 Years

Date Range of Records to be Released: Start Date:______________ End Date:_________________

____**All Dates of Care** (Entire Record) (**NOTE**: if records are extensive, the receiving practice may not have time to review or the space to import all your older files.)

I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in processing it. Once this information is released it may no longer be protected by the federal privacy regulations and may be re-disclosed.

I understand that the specified information released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that this authorization will remain in effect for, and expire in, one year from the date it was signed unless I specify a date here (ALLOW AT LEAST TWO WEEKS):__________________________ .

I understand there may be a charge for my records. Charges will be based on labor time and media/postage fees. The least amount charged is $10.00. Transferring records from doctor to doctor will not incur charges for the first release.

______________________________	______________________
Signature of Patient or Legal Representative	Date
______________________________	______________________
Printed Name & Relationship to Patient	Witness