MobileMed
Onsite Insight

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

TODAY'S DATE: _____ /_____/ _____

PATIENT NAME:_____

DATE OF BIRTH: _____ /_____/ _____ _____

Phone:_____ Email:_____

Records Released *From*:

Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

Records Released *To*:

Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

Information to be Release/Obtained:

□ Complete Medical Record □ Lab Reports □ Billing Records □ Clinical Records Related To:

_____

_____

- I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand I have the right to revoke this authorization, in writing, at any time. The revocation will not apply to information that has already been released as a result of this authorization.
- I understand that the PHI used, disclosed, or released pursuant to this authorization may be subject to redisclosure by the recipient of my PHI and will no longer be protected by state or federal privacy regulations.
- I understand that MOBILE MED may charge a fee for copying and sending my records.
- I understand that requests may take up to 72 hours.
- I authorize *MOBILE MED* to release or obtain medical records as specified above.

SIGNATURE (Patient or Authorized Representative) _____ Date____/_____/_____

PRINTED NAME (Patient or Authorized Representative) _____