Mathiesen Memorial Health Clinic

Request for Patient Records

Patient Name _____

Address _____

Social Security #_____ Date of Birth _____

Send Records from:_____

Send or Fax Records to **Mathiesen Memorial Health Clinic**
P.O.Box 535
Jamestown, CA 95327
209-984-4820
Fax : 209-984-4825

1. I authorize the use or disclosure of the above-named individual's health information, as described below.

2. The type and amount of information requested:

   □ Problem list □Medication list □Drug sensitivities

   □Most recent progress notes from_____(date) to _____(date)

   □Laboratory results from _____(date) to _____ (date)

   □X-ray and/or imaging reports from _____(date) to _____(date)

   □Entire record □Immunization record

   □Other (please describe) _____

3. This information is being disclosed for the following purpose(s):
   □continuity of care_____

4. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to ***Mathiesen Memorial Health Clinic***. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Name_____DOB_____MR#_____

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5. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____
   [Optional] If I fail to specify and expiration date, event, or condition, this authorization will expire twelve (12) months from the date of signing.

6. I understand that once the information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

7. I understand that if I refuse to sign this form, Mathiesen Memorial Health Clinic can refuse (select all that apply):

   □ treatment □ enrollment in the health plan □ eligibility for benefits

Signature of Patient or Legal Representative_____Date_____

If signed by legal representative, relationship to patient_____

Signature of Witness_____ Date_____

Patient Name _____DOB _____MR# _____