Arete Family Care, LLC
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Permission To Request Medical Records

Patient Name: ______________________________ Date of Birth: ________________

I am the: ☐ Patient ☐ Parent/guardian Other: _____________________________

Phone Number: __________________ Last 4 digits of SS# (optional): _______

I authorize ***ARETE FAMILY CARE, LLC*** to request my medical records from:

Practice name: ____

Practice phone: __________________ Practice fax:____________________

Practice address: ____

Request type: ☐ Fax to Arete ☐ Mail copy to Arete

Purpose of disclosure: ☐ Continuity of care ☐Other: ________________________________

By checking the boxes below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

☐ ALL MEDICAL RECORDS

☐ Chart notes: ☐ All ☐ From: __________ to __________

☐ Labs: ☐ All ☐ From: __________ to __________

☐ Radiology reports: ☐ All ☐ From: __________ to __________

☐ Immunization records ☐ Other (please specify): ______________________________

PLEASE INITIAL the items below for this information to be included in the use or disclosure of other health information:

Federal regulations require a description of how much of what kind of information is disclosed. Federal law prohibits the re-disclosure of such information, only with authorization:

This Section Must Be Completed

___ Yes, disclose ___ No, do not disclose - HIV/AIDS related health information and/or records

___ Yes, disclose ___ No, do not disclose - Mental health information and/or records

___ Yes, disclose ___ No, do not disclose - Drug/alcohol diagnosis, treatment, and/or referral information

Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon the following date (or condition, or event of expiration): ______________________________

Exception to the extent that action has already been taken in reliance upon the authorization, I understanding that I may revoke this authorization at any given time by giving written notice. I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. **Please allow 10 business days for processing.**

______________________________________ ________________________

Signature of Patient or Patient's Legal Representative Date

______________________________________ ________________________

Print name of Legal Representative (if applicable) Relationship of Legal Representative to Patient