Physicians East, P.A.
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Chart Number: _____

Information to be disclosed/released:

☐ Office Visit Notes ☐ Consultation Reports ☐ Laboratory Results ☐ Diagnostic Reports ☐ Procedure Reports ☐ Radiology Reports

☐ Billing Information ☐ CD of Diagnostic Image ☐ Immunizations ☐ Other (please specify): _____

I give special permission to release any information regarding: (Items for special permission must be checked and initialed)

☐ Mental Health/Substance and/or Alcohol Abuse ____ ☐ Treatment for Abortion and/or Contraceptive Management _____ ☐ HIV/AIDS Information ____ ☐ Drug Screening Test _____ ☐ Genetic Testing Information _____

Purpose: ☐ Continuity of Care ☐ At the Request of the Individual ☐ Transfer of Care ☐ Legal/Insurance ☐ Other: _____

Authorization: I request and authorize Physicians East to: ☐ send/provide records/information to ☐ receive records/information from

Facility/Individual: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Fax Number: _____

This information will cover the period(s) of healthcare from _____ to _____.
Date **Date**

Provide by: ☐ Fax ☐ Mail ☐ Pick Up Electronically: via ☐ CD ☐ USB (patient is responsible for cost of device) ☐ Portal

I understand this authorization can be revoked by writing to the Physicians East, P.A. Privacy Officer or filling out a form (Ref. FM0018) at any time, except to the extent that action has been taken in accordance with this authorization. Unless otherwise revoked, this authorization will expire in:

☐ 90 days; ☐ one year; ☐ other: (can not exceed one year) _____. If I fail to specify an expiration date, this authorization will expire one year from the date on which it was signed.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I also 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 redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
All requests will be handled within 30 days. The cost for copying your medical records is dependent on the number of pages. The charge is $.75 per page for the first twenty five pages, $.50 per page for pages twenty six to one hundred and $.25 per page for each page over one hundred. There will be a charge based on the number of pages copied for requests made and not picked up after 60 days. There is no charge for the duplication of records made directly to another health care provider. For electronic requests, the fee is based on the time spent to create and copy the information. Physicians East does not accept portable devices brought in. If information is placed on a portable device, the cost of the device will be included in the fee. There is not charge for requests processed via the Patient Portal.

Patient Signature: _____ Date: _____

Personal Representative Signature (if not the patient): _____ Date: _____

Printed Representative's Name: _____ Relationship to Patient: _____

Physicians East Representative Signature: _____ Date: _____

Printed Physician East Representative Name: _____

A Notary Public must witness the patient/personal representative's signature on request not completed at Physicians East.

Notary Public: _____ Date: _____

Sworn to and subscribed before me this _____ day of _____ 20____.

My commission expires: _____.

PE Authorization to Release Health Information
Revised: 1/2015
Original: PE Record
Copy: Patient