Consent to Release Medical Information

Troy Family Practice, PLLC

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Stacey Beltz, DO Ann Forde, NP-C Kathrine Kranz, PA-C Brittany David, PA-C

Patient's Name:_____ Birthdate:_____

Records Requested From:

_____

_____

_____

_____

I authorize the release of my medical records to the above named practice, these records are to _____ include or _____ exclude information relating to the treatment of substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment for sexually transmitted disease including HIV/AIDS

My above choice applies to all information in my medical record protected under HIPPA.

These records are being requested for the following reasons:

_____ Moving to a new area

_____ Seeing a specialist

_____ Insurance change

_____ Update primary care provider/office

_____ Other, please comment

*****WE ARE THE PATIENT'S PRIMARY CARE PHYSICIAN"S OFFICE*****

*****Please DO NOT fax records if greater than 20 pages.*****

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I may revoke this consent at any time by written request and understand that the release is effective for six (6) months. Records forwarded from a previous physician and generated before my relationship with Troy Family Practice, PLLC., may be released with the authorization of either Stacey Beltz, DO, Ann Forde, NP-C, Kathrine Kranz, PA-C or Brittany David, PA-C.

_____

(Signature of Patient or Patient's Legal Guardian) **(Date)**

_____

(Signature of Witness) **(Date)**