CHURCHVILLE-CHILI FAMILY MEDICINE
4201 Buffalo Road – P.O. Box 505, N. Chili, NY, 14514
Tel: (585) 594-5995 - Fax: (585) 594-5425

Patient Name: _____ Date of Birth: _____

Medical Records Released to:

We have received a request for medical records from the above office. Due to HIPAA regulation, we have amended our current release process which requires that our own *Authorization To Release Medical Information Form* be signed prior to medical records being transferred. Please sign, date and return the attached form.

Our charge to copy an entire electronic medical record to CD and mail it, is $6.50. Our charge to send your medical record via secure fax is $6.50 The charge to copy medical records to paper varies according to the number of pages. We also offer a *summary* of electronic medical records which is free of charge. **We will be happy to transfer your records upon receipt of the attached form and payment**. Once received, your request will be processed within 7 business days.

If you are transferring to a new office, your status will be updated on the date that our records of your care have been sent to the new PCP office for them to provide ongoing care.

Please select one of the following options:

- ☐ Please copy and mail my entire medical record on **CD** to the above address for $6.50. *(I have contacted my new healthcare provider's office and verified that they will accept my records on CD)*
- ☐ Please **fax** my records to my new physician's office @ $6.50
- ☐ Please copy my records to **paper** @ .75 per page (*please contact our office for total cost*)
- ☐ Please send only a **free summary** of my electronic medical record to the above address.

Thank you for your assistance.

Churchville-Chili Family Medicine
Medical Records Department

FOR OFFICE USE :

$_____ Pre-Payment received by _____ on _____

STATUS: ☐ Trans ☐ Rel ☐ Other _____ DATE:_____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name:		Date of Birth :
Address:		
City:	State:	Zip :
Phone :		

☐ I authorize Churchville-Chili Family Medicine to **OBTAIN** information from my previous health care provider:

Name of Provider, Facility or other person
Address
City, State, Zip
Phone/Fax # (include area code)

☐ I authorize Churchville-Chili Family Medicine to **RELEASE** my information to my new health care provider:

Name of Provider, Facility or other person
Address
City, State, Zip
Phone/Fax # (include area code)

PURPOSE FOR THIS REQUEST : Changing Physicians ☐ Insurance Coverage ☐ Personal ☐ Other ☐

TYPE OF RECORDS REQUESTED :

☐ Treatment summary (includes history/physical, laboratory tests & reports, pathology)

☒ Entire copy of patient record (NOTICE: this would include ALL sensitive information in your chart such as any HIV related information, mental health related care, substance abuse diagnosis and treatment, etc.)

☐ All medical records related to a specific illness or injury : _____

_____

☐ Specific timeframe : Dates from : _____ to _____

AUTHORIZATION VALID FOR :

☐ This request only ☒ One year from the date of this authorization (this authorization applies to the records of the treatment received on or prior to the date of this authorization.)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- There may be a charge for records requested from Churchville-Chili Family Medicine.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is a not a healthcare or medical insurance provider covered by privacy regulations, the information in your record requested above could be disclosed.
- Request for complete records will include any sensitive information contained therein, such as HIV-related information, substance abuse diagnosis and treatment, mental health related care, etc.

Signature of Patient or Representative: _____ Date : _____

Relationship to patient (if requester is not the patient) : _____