Envision
PHYSICIAN SERVICES

Medical Records Release Authorization Form

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

Patient Name: _____ Date of Birth: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ **Last three Office/Procedure Notes – OR – Dates from_____ to _____**

☐ **All imaging reports for the last two years**

☐ **Last three months of urine drug screens**

☐ **Other: _____**

I understand the following: See CFR 164.508(c)(2)(i-iii). I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. The information released in response to this authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires. Envision Physician Services is only authorized to release records produced or ordered by our clinicians and physicians.

I HEREBY AUTHORIZE RELEASE MY MEDICAL RECORDS TO:

_____

Name of healthcare provider or other entity

_____

Phone Number

I authorize my records be sent via (check only one):

☐ **Fax Number _____**

☐ **Email: _____**

_____ _____

Signature of Patient or Legally Authorized Representative **Date**