MERIDIAN
INTERNAL MEDICINE AND PRIMARY CARE, INC.
we're all about YOU!

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Confidential Medical Records Request

Patient Information

Patient Name _____

Date of Birth _____ Social Security Number _____

Holder of Medical Records

Name of Clinic or Physician _____

Address _____

Phone/Fax Numbers _____

At the time I am requesting the following:

o Complete Record

o Records of care from _____ to _____ only.

o Records of care concerning the following condition(s) _____

o Other, specify _____

Patient Consent and Authorization to Release Medical Records

1. This authorization is valid for ninety (90) days from the date signed. I understand this consent can be revoked by me any time before disclosure has occurred.

2. Unless specifically excluded, this authorization includes release of specially protected records-such as referral to, diagnosis of, and/or treatment for substance abuse, mental health conditions, and sexually transmitted diseases such as HIV.

3. I understand that records of my healthcare are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent unless otherwise provided for or allowed by these regulations.

Patient/Guardian Signature _____

Today's Date_____

Witness _____

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