myhomedoctor

My Home Doctor, LLC
Tel 888.696.4322 · Fax 877.409.3320

PATIENT FORMS

Authorization for release of medical information

STEP 1

Patient information

FIRST NAME *

MIDDLE NAME

LAST NAME *

DATE OF BIRTH *

mm/dd/yyyy

MOBILE PHONE

ADDRESS

ADDRESS LINE 2

CITY

STATE

ZIP

STEP 2

Requested from

The provider who has your records. Leave blank anything you don't know.

NAME OF PROVIDER

PROVIDER EMAIL

PROVIDER PHONE

PROVIDER FAX

ADDRESS

ADDRESS LINE 2

CITY

STATE

ZIP

CONFIDENTIAL: This form contains protected health information (PHI). Do not leave it unattended or share it with anyone other than My Home Doctor or your authorized representative.

STEP 3

Send information to

RECIPIENT

My Home Doctor, LLC

PHONE

888.696.4322

FAX

877.409.3320

EMAIL

records@myhomedoctor.com

STEP 4

Purpose: treatment and continuity of care

I authorize the release of my health information for the following specific purpose:

- ◯ At the request of the medical provider
- ◯ At the request of the patient

STEP 5

Information to be disclosed

I authorize the release of the following health information:

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

INFORMATION REQUESTED

- ☐ Entire medical report
- ☐ Progress & consultation notes
- ☐ Diagnostic reports
- ☐ Behavioral health records only
- ☐ Other

LIST TYPE(S) OF HEALTH INFORMATION LIMITED TO

STEP 6

Term

I understand that this authorization will remain in effect:

- ◯ From the date of this authorization for a period of two years
- ◯ Until the provider fulfills this request
- ◯ Until the following date

UNTIL DATE

mm/dd/yyyy

STEP 7

Please read

Redisclosure. I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign / right to revoke. I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

STEP 8

Authorization

I, _____, authorize the release of confidential health information about me. You may release a copy of my medical records, or a summary or narrative of my protected health information to My Home Doctor, LLC.

PATIENT OR REPRESENTATIVE SIGNATURE *

SIGN HERE

DATE *

mm/dd/yyyy

IF THE PATIENT IS UNABLE TO SIGN

Legal guardian or power of attorney

Complete this section only if the patient is unable to sign this authorization.

☐ I have a signed Power of Attorney and will provide it to My Home Doctor, LLC

GUARDIAN / POA FIRST NAME

GUARDIAN / POA LAST NAME

LEGAL RELATIONSHIP

PHONE NUMBER