CHRISTINE MEYER, MD and associates

750 West Lincoln Highway, Exton, PA 19341
P: (610) 363-0100 F: (610) 363-3923

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of medical records.

PATIENT NAME: _____ Date of Birth: __/__/____

Address: _____

_____

Phone: (_____) _____ - _____ Email address: _____

Release my information: { *Please be aware that there may be a fee charged for copying your records.}*

☐ from ☐ to ☐ from ☐ to

Christine Meyer, MD and Associates
750 West Lincoln Highway
Exton, PA 19341
Phone: (610) 363 – 0100
Fax: (610) 363 – 3923

Recipient Name: _____
Street Address: _____
City, State, Zip: _____
Phone: ( ) _____ - _____
Fax: ( ) _____ - _____

Dates of Information to be Disclosed: From _____ to _____

This authorization is valid for one year or the following specific date: __/___/___

Reason for Disclosure of Records:
(Please check all that apply.)

- ☐ Continuity of Care
- ☐ Relocation
- ☐ Change of PCP
- ☐ Disability Determination
- ☐ Insurance/Benefits
- ☐ Legal Investigation/Action
- ☐ Other _____

Information to Disclose:
(Please check all that apply.)

- ☐ All Records
- ☐ Records for previous 2 Years
- ☐ Immunization Records
- ☐ Laboratory/Pathology Records
- ☐ Radiology Records
- ☐ EKG/Test Results
- ☐ Other _____

Information that I do not want to be disclosed:

☐ Alcohol/Substance Abuse ☐ HIV Test Results ☐ Mental Health Records ☐ Genetic Testing Results

I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this authorization. In addition, I understand that I do not need to sign this authorization to receive treatment. I am also aware that I may revoke this authorization by notifying the disclosing medical records department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition of obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ Date: ___/___/____

Signature of patient (or patient's personal representative)

_____ _____

Printed name of patient representative

Representative authority to sign for patient
(i.e. parent, guardian, POA, executor)