Release (Authorization) To Copy Medical Records / Information – Page 1 of 2 - Updated 2022

Amber Health Care for Women – the Office of Dr. Cheryl Serr 1842 Buenaventura Blvd Redding CA 96001 P: 530-225-8500

To get a copy of your medical records: By law you are entitled to a copy of your medical records. A doctor's office, storage facility, or copy service also have the legal right to charge a fee to produce this copy. If you need five pages or less - such as a copy of your last visit, pap and mammogram - our office will provide a free copy. If you require more extensive records, our office is contracted with Professional Medical Copy Service.

You need to sign a Release to Copy Medical Records Form. To protect your privacy and comply with federal HIPAA Guidelines, and federal / state guidelines and laws regarding the release of medical records / private health information, you will need to sign a Medical Records Release form before our office can release (copy or send) your medical records. You can use our form (below) or obtain one from your new doctor's office. This form is available both at our office and on our website (under "Our Office/Forms") @ Amberhealthcareforwomen.com. If you need a copy of records from another doctor's office sent to our office: sign a Release to Copy Medical Records Form (ours or one from your other doctor) and either mail it to your other doctor's office or we can fax it. If you need a copy of your records from Amber Health Care for Women: sign a Release to Copy Medical Records Form (ours or one from your new doctor) and have it sent to our office.

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This Authorization allows the healthcare provider(s) named below to release confidential medical records / information. Please initial along the left side, check all boxes that apply and sign at the bottom of this Authorization.

Patient Name: _____ Date of Birth: _____

I authorize records to be released **FROM**
(Name and complete address):

_____
_____
_____
phone: _____
fax: _____

I authorize records to be released **TO**
(Name and complete address):

_____
_____
_____
phone: _____
fax: _____

_____ (Initials) Authorization: I authorize the release (copy) of my private medical records regarding my medical history, including illness or injury, consultations, prescriptions, treatment, diagnosis, prognosis, test results (lab and radiology), genetic testing, correspondence and phone notes, and including records from my other health care providers that my current healthcare provider may have, by means of mail, fax, or other electronic methods. Please mark below which records are to be released.

☐ All of my records (including: STD/HIV/AIDS, alcohol / substance abuse, psychiatric / mental health records)

☐ Pregnancy records (including: STD/HIV/AIDS, alcohol / substance abuse, psychiatric / mental health records)

☐ Limited (only some of my records):
- ☐ most recent pap smear
- ☐ operative and pathology report from surgery: _____
- ☐ emergency room visit records (including labs and radiology) from: _____
- ☐ other: _____

☐ All of my records except: ☐ STDs/HIV/AIDS ☐ behavioral / mental health ☐ alcohol / substance abuse

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_____ (Initials) Special Acknowledgement: I understand that the information in my medical records may include information relating to the testing or treatment of sexually transmitted diseases, including human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), information about behavioral or mental health services, or information about alcohol and drug abuse. I understand that this information cannot be released without my specific consent.

_____ (Initials) Use of Information: The recipient identified above is permitted to use my medical records for the following purpose: ☐ medical care ☐ insurance ☐ legal ☐ other: _____

_____ (Initials) Expiration and Cancellation: I understand that unless otherwise revoked / cancelled, this authorization will remain in effect until it expires, one year from the date of the signature below. I understand that I have a right to revoke (cancel) this authorization at any time, and that I must do so in writing and submit it to my healthcare provider / facility. I understand that the revocation will not apply to records that have already been released. I understand that the revocation will not apply to my insurance company, when the law provides my insurer with the right to contest a claim under my policy.

_____ (Initials) Understanding: I understand that authorizing the release of my medical records is voluntary, and that I can refuse to sign this authorization, and that I will not be denied treatment for refusing to sign this form.

_____ (Initials) Understandings: I understand that my health care provider cannot guarantee that the recipient of my medical records will not redisclose my medical records to a third party, which may or may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my medical records. I understand that I have a right to receive a copy of this authorization. I understand that a photocopy or facsimile of this authorization will be considered as effective and valid as the original.

_____ (Initials) Fee: I understand that there will be a fee to copy my records, as governed by the California Health and Safety Code # 123110**.** For records released from Amber Health Care for Women: Our office is contracted with Professional Medical Copy Service. I understand that this company will invoice me for their services and I agree to pay. Call 241-2971 with any questions.

Signature: By signing below, I acknowledge I have read and understand pages 1 and 2 of this authorization.

_____

Signature of patient (or legal representative - list relationship to patient) Date

_____

Name of patient (PRINT) Patient's Social Security Number Patient's Date of Birth