Medical Record Request for Records From Our office

Patient Identification	**FAX**
Patient Name:_____ Date of Birth:_____	**Today's Date:**

Medical Record Request to send records

To: Doctor or Medical Office

Fax:_____
Phone:
_____

From:

Steven D. Atwood, MD, FACP
Medical South Building on Walnut Lawn
3525 S. National # 206
Springfield, MO 65807

Fax: 417-**269-9204**
Phone: 269-9200

I hereby request and authorize you to send

your recent progress notes, and test results and other key records to the fax # noted above.

Data to exclude and not send is_____.

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis testing, HIV/AIDS (Human Immunodeficiency Virus / AIDS) testing and/or treatment and/or other sensitive information, and I agree to its release

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records that those records are protected by Federal Law. This authorization for release of information form does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse prohibit information disclosed from records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that once information is released to the above named person or office, my information may be subject to re-disclosure and no longer protected by the Federal privacy regulations. . I can inspect or copy the protected health information to be used or disclosed If I wish to stop by the office.
I authorize Dr. Atwood to use and disclose the protected health information specified above.

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Dr. Atwood's office. Unless revoked, this authorization will expire on the following date

_____, or one year from date of signature, unless otherwise specified.

_____ _____
Signature of Patient Date

_____
Print Name