Franciscan
PHYSICIAN NETWORK

Request for Health Information from Another Facility/Office

Requesting Medical Records from the following facility/Office:

_____

INFORMATION TO BE RELEASED TO:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

PATIENT INFORMATION

Patient name (Please print): _____

Patient Address: _____

Date of Birth: _____Last 4 digits of Social Security # _____Patient Telephone#_____

Covering the period (s) of treatment: _____

PURPOSE OF DISCLOSURE: _____ Continuation of Care

INFORMATION TO BE RELEASED:

____Discharge Summary	_____ Radiology (Xray, CT scan, MRI)	_____ Lab Results
____History and Physical	_____EKG	_____ Operative Report
____Complete Health Record	_____ Other (Specify): _____	

We are requesting this information for the continuity of care for the patient listed above. This request is in compliance with 45 CFR 164 of the Health Insurance Portability and Accountability Act (HIPAA) which allows release of information without explicit patient consent for treatment, payment, and healthcare operations.

Signature: _____Date: _____

Relationship to patient, of other than patient: _____

Description of AUTHORITY TO ACT FOR PATIENT (if applicable): _____

WITNESS SIGNATURE: _____Date: _____