Legacy Medical Group
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AUTHORIZATION TO RELEASE / REQUEST MEDICAL RECORDS INFORMATION

Physician we are requesting medical information from: _____

I authorize the custodian of records to disclose/release my medical information.

☐ All records ☐ X-ray/radiology ☐ Lab/pathology records ☐ Other (describe)_____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information. I understand that after custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient Name _____ Phone _____ DOB _____

Signature of Patient _____ Date _____

Or

Signature of Guardian _____ Date _____

Printed Name of Guardian _____

PLEASE INCLUDE A COPY OF YOUR POWER OR ATTORNEY OR GUARDIANSHIP FORM, IF AVAILABLE.

FOR PHYSICIAN OFFICE: *Please mail records instead of faxing, if over 50 pages. If you do not have any records for this patient, please provide us with a brief explanation. This authorization expires one year after it has been signed.*