PHONE#: 828-294-4100

Unifour FamilyPractice

2874 NC HWY 127 South
Hickory, NC 28602

Fax: 800-951-8614

MEDICAL RECORD REQUEST FORM

All disclosures are in compliance with Federal and State laws, including the Health Information Portability and Accountability Act (HIPAA), governing the use and disclosure of Protected Health Information (PHI).

IF MORE THAN 50 PAGES PLEASE MAIL

PRINTED NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

TELEPHONE #:_____ PREVIOUS NAME RECORDS MAY BE UNDER:_____

I HEREBY AUTHORIZE UNIFOUR FAMILY PRACTICE:

☐ TO OBTAIN MY RECORDS FROM: _____

FAX#_____ PHONE#_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

FOR THE PURPOSE OF: **(PLEASE CHECK ONE)**

- o TRANSFER OF CARE
- o CONTINUING CARE
- o CONSULTATION
- o OTHER (LIST REASON)_____

INFORMATION REQUESTED INCLUDES:

☐ ALL MEDICAL RECORDS WITHOUT EXCEPTIONS.

☐ PARTIAL MEDICAL RECORDS: PLEASE SPECIFY PARTS AND DATES TO BE RELEASED.

- o PROGRESS NOTES _____
- o X-RAY REPORTS _____
- o LAB REPORTS_____
- o GYN REPORTS _____
- o IMMUNIZATIONS _____
- o ALLERGY_____
- o PHYSICAL _____
- o CONSULTATIONS_____

OTHER:_____

Information Requested: I hereby agree to this authorization. Please Note: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information and any information relating to HIV testing, AIDS, and AIDS related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I understand that I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing, to Unifour Family Practice. Unless revoked, this authorization will expire in one year from the date of signature. If I choose to limit the information released, I understand that I may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to re-disclosure by the recipient and no longer be protected by Unifour Family Practice. Unifour Family Practice and its staff are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Patients Legal Representative (Relationship) Date

_____ _____

Witness Date

Note to recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Laws including, HIPAA and prohibits you from further disclosure without the written consent to whom it pertains. Charges may apply for copies of medical records.