Genesis HEALTHCARE

3444 Kearny Villa Rd., Suite 300
San Diego, CA 92123
T 858.888.7700
F 858.221.5062
mygenesishealth.com

PATIENT REQUEST FOR MEDICAL RECORDS

1. **Authorization: I authorize disclosure of protected health information (PHI) as described below.**

   Name of Patient: _____

   Telephone: (___) _____ Date of Birth:___/ ___ /_____

2. **Release Records To (Please specify if different from patient):**

   Name: _____

   Address: _____

   Telephone: (___) _____

3. **Requested Records:**

   ☐ Office Notes
   ☐ Operative/Procedure Reports
   ☐ Laboratory Results (Excluding HIV Test Results)
   ☐ Non-Genesis Healthcare Records (Lab results, Operative /Procedure Reports, History & Physical Reports)
   ☐ All Medical Records
   ☐ Other _____

4. **Dates of Service:** From:___/ ___ /_____ To:___/ ___ /_____

5. **Use of Information:**

   ☐ Continuing Care ☐ Personal ☐ Insurance Claim ☐ Other _____

6. **Delivery Method:**

   ☐ Pick up in office ☐ Fax to _____
   ☐ Mail to: _____
   ☐ Send electronically to my Genesis Web Portal account. If you do not have a Genesis Web Portal account, please provide your e-mail address to set up one. _____

7. **Consent/Authorization:** The information/records will be used for the following purpose:_____

   This authorization is:

   □ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

   □ Limited to the following medical information:_____

   I also consent to the specific release of the following records:

   Drug/Alcohol/Substance Abuse_____(initials) HIV Diagnosis/Treatment _____(initials)

   Psychiatric/Mental Health _____(initials) Genetic Information _____(initials)

   Tests for Antibodies to HIV _____(initials)

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8. Authorization Expiration Date:

If none specified, authorization will expire one year from date of signature. Date: ___/ ___/ _____

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that my medical care will not be conditioned on whether I sign this authorization.

9. Signature:

Patient or Legal Representative:_____ Date: ___/ ___/ _____

If signed by someone other than the patient, indicate relationship _____