ULRIKA HOLM – CHAPMAN, M.D. PLLC

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Our Promise of Privacy and Consent to Patient Medical Records (HIPPAA). Our office is fully committed to compliance with HIPPAA guidelines by requesting the following information for record release:

Patient Name: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Former Name (if any): _____ SS#: _____

Daytime #: _____ Cell #: _____

Will you be returning to our office for future care? YES NO

Purpose or need for this information: _____

I authorize Dr. Ulrika Holm – Chapman, M.D. PLLC to **send to / receive from** (circle one)

Name of Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # : _____ Fax # : _____

( ) I hereby consent to the release of **ALL** medical records **INCLUDING** information protected by state / federal law related to alcohol and drug abuse, psychological illness, sexually transmitted disease and **HIV** testing unless otherwise directed below.

( ) I hereby consent to the release of **ALL** my medical records **EXCEPT** information protected by state / federal law as listed above.

( ) Specific records only as checked below:

( ) OB/GYN RECORDS
( ) SURGICAL REPORTS
( ) LAB REPORTS
( ) X-RAY REPORTS
( ) PATHOLOGY REPORTS
( ) CONSULT REPORTS

( ) OTHER, PLEASE SPECIFY: _____

I release the Physician and employees of Dr. Ulrika Holm – Chapman, M.D. PLLC for any liability arising from the release of this information to the above stated person (s) or facility, provided the said release is performed in accordance with the applicable law.

_____ _____
Signature of Patient/Guardian (legal representative) Relationship to Patient signed by Guardian

_____ _____
Date Signed Witness