Medical Records Release

Patient Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Daytime Phone: ______________________

I hereby authorize Bella Family Healthcare & Aesthetics to request Medical Information from:

(Previous Provider)

Name: ______________________ Phone: ______________________

Address: ______________________ Fax: ______________________

City: ______________ State: ______________ Zip ______________

I AUTHORIZE THE FOLLOWING TO BE RELEASED:

_____ COMPLETE MEDICAL RECORD (All healthcare information including immunization records, wellness physicals, progress notes, labs, advanced imaging, medications, allergies, specialist notes, etc.)

_____ Other (please specify): ____

Reason for Request: ☐Continued Treatment ☐ Transfer of Care ☐ Other________________________
____

I AUTHORIZE THE ABOVE INFORMATION TO BE RELEASED TO:
BELLA FAMILY HEALTHCARE & AESTHETICS
1545 E LEIGHFIELD DR STE 100
P. 208-957-6871 F. 208-957-6872

In accordance with HIPAA laws, this release is in effect for one year after today, or when patient revokes.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to use or disclosure of my protected healthcare information for purposes of treatment, payment, or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized Bella Family Healthcare & Aesthetics to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original. I understand that I may revoke this authorization in writing at any time to Bella Family Healthcare & Aesthetics, except to the extent that the information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have marked no and initialed it.

YES ☐ NO ☐ INITALS:_____________

______________________________ ______________________ ______________________

Signature/Legal Responsible Party Relationship to Patient Date