MOSCOW MEDICAL
where you matter

213 N. Main St, Moscow, ID 83843
Telephone: 208-882-7565 Fax: 208-882-7567

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth: _____

Other (Maiden) Name:_____ Patient Phone Number: _____

Records From:

_____

Phone: _____

Fax: _____

Records To:

_____

Phone: _____

Fax: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I release Moscow Medical and its staff from all the legal responsibility or liability that may arise from the release of this information. This consent may be revoked by me at any time, except when action has been taken, by contacting Moscow Medical. This release will expire in 60 days, from the date signed below. I understand that there may be a charge for this service, and agree to pay said charges.

Purpose for which disclosure is being made:

____ Transfer (limited to 3 years) ____ Insurance ____ Legal Request ____ Personal/Other

The information that I request to be released is:

____ All Records Dates from _____ to _____

____ Progress Notes ____ Laboratory Notes ____ Imaging Reports ____ EKG Reports ____ Immunizations

____ Other: _____

Patient/Guardian Signature: _____ Date: _____

Relationship of Guardian: _____