Permission to Request Patient Health Information

Patient Info

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone Number: _____

I authorize ConvenientMD Primary Care to request my health information from the following entities:

Office Name: _____ Provider Name: _____
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Office Name: _____ Provider Name: _____
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Office Name: _____ Provider Name: _____
Street Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Purpose of Disclosure:

☐ Medical Care ☐ Legal Transferring to a new provider
☐ Insurance ☐ Other _____

Select from the below list the health information that is to be shared:

☐ Abstract (cover page of any medical reports)
☐ Discharge summary
☐ Inpatient progress notes
☐ Outpatient visit (office) notes
☐ Emergency department reports
☐ Laboratory/pathology reports
☐ School physical forms
☐ Immunizations
☐ Operative reports
☐ X-ray reports
☐ X-ray films
☐ Other : _____
☐ Records from a specific provider: _____

Sensitive Health Information:

The following types of information will NOT be requested to be released from your current provider to ConvenientMD unless you place your initials in the space provided.

_____ ☐ Mental Health Treatment Records
_____ ☐ Genetic Testing
_____ ☐ Alcohol/ Drug abuse treatment records including addiction treatments
_____ ☐ Sexually Transmitted Disease Treatment Records
_____ ☐ HIV/AIDS test results

Duration & Revocation: This authorization will auto renew in one year from the date of the signature below unless specified otherwise here (date): _____ /_____ /_____ . You or your personal representative may revoke this authorization at any time by providing written notice. However, your revocation will not apply to any previously released information.

_____ _____
Signature of Individual or Responsible Party **Date**

_____ _____
Printed Name of Patient or Responsible Party **Date**

For Doctor's Office Use Only:

Please send any patient forms to ConvenientMD via secure email - primarycare@convenientmd.com
or fax 1 (603) 319-5898