Bellevue Family Practice, P.C.

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For Internal Use Only

DATE: _____/_____/_____
COMPLETED: ☐ CDorUSB ($10 + search fee) ☐ PAPER ($0.50/pg + search
DELIVERED VIA: ☐ FAX ☐ MAIL ($4.65) ☐ PICKUP
CHARGES: ☐ N/A ☐ $_____
CHARGES ENTERED IN NEXTGEN: ☐ YES
COMPLETED BY: _____

1. Patient Name: _____ Birth Date: _____/_____/_____

   Address: _____ Phone Number: (___)____-_____

2. I hereby authorize and request release of my medical records:

   FROM: _____
   (Health Care Facility to send information)

   _____
   (Street Address) (City) (State) (Zip)

   (_____)_____-_____ (_____)_____-_____
   (Phone Number) (Fax Number)

   TO: _____
   (Name of Institute or Individual to receive information)

   _____
   (Street Address) (City) (State) (Zip)

   (_____)_____-_____ (_____)_____-_____
   (Phone Number) (Fax Number)

3. Information to be disclosed:
   - ☐ Complete Medical Chart
   - ☐ Immunization Record
   - ☐ Records from Specific Dates: _____/_____/_____ to _____/_____/_____
   - ☐ Other: _____

   ☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I must give specific written permission before disclosure of these test results to anyone.

   ☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

4. Purpose of release: ☐ Transfer of Care ☐ Personal Use ☐ Referral ☐ Other: _____

_____ By initialing, I understand that there may be a fee associated with processing this records release request. Fees that may apply: $20 search fee + $10 for records put on a disc/usb or $0.50/page for paper copies. An additional $4.65 will be charged if records are to be mailed from our office.

Patient Signature: _____ Date: _____/_____/_____

This authorization expires ninety days after it is signed

71-8403. Access to medical records. (1) A patient may request a copy of the patient's medical records or may request to examine such records. Access to such records shall be provided upon request pursuant to sections 71-8401 to 71-8407, except that mental health medical records may be withheld if any treating physician, psychologist, or mental health practitioner determines in his or her professional opinion that release of the records would not be in the interest of the patient unless the release is required by court order. The request and any authorization shall be in writing. If an authorization does not contain an expiration date or specify an event occurrence of which causes the authorization to expire, the authorization shall expire 12 months after the date the authorization was executed by the patient. (2) Upon receiving a written request for a copy of the patient's medical records under subsection (1) of this section, the provider shall furnish the person making the request a copy of such records no later than thirty days after the written request is received.