NP Pulse

Professional Care. Personal Touch. Right at Home.

Authorization to Obtain Medical Records

Patient Information

Name: ______________________ Date of Birth: ______________

Address: ______________________ Phone Number: ______________

Authorization

I hereby authorize any physician, hospital, clinic, laboratory, pharmacy, insurance company, or other healthcare provider to **release my medical records to:**

NP PulseOnTheGo House Calls, PLLC

Phone: ______________ Fax: ______________

Address: ______________________

Information to be Released (check all that apply)

☐ Complete Medical Record
☐ History & Physical
☐ Progress / Office Visit Notes
☐ Hospital Records
☐ Laboratory Results
☐ Radiology / Imaging Reports
☐ Medication List
☐ Immunization Records
☐ Billing Records
☐ Other: ______________________

Date Range of Records

From: ______________ To: ______________

☐ All Available Dates

Purpose of Disclosure

☐ Continuing Medical Care / Treatment
☐ Care Coordination
☐ Insurance / Billing
☐ Other: ______________________

Method of Delivery

☐ Fax to: ______________________
☐ Secure Email: ______________________
☐ Mail
☐ Electronic Medical Record Transfer

Sensitive Information

I understand that this authorization may include the release of information related to:

☐ Mental Health Records
☐ HIV/AIDS Information
☐ Substance Use Treatment Records

(Initial if applicable): ______________

Expiration

This authorization will expire **one (1) year from the date signed** unless otherwise specified.

Expiration Date (optional): ______________

Patient Acknowledgment

I understand that:

- I may revoke this authorization in writing at any time.
- My treatment, payment, or eligibility for benefits will not be conditioned on signing this authorization.
- Information disclosed may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

Signature

Patient / Legal Representative Name: ______________________

Signature: ______________________ Date: ______________

If signed by legal representative, relationship to patient: ______________________