623 S Main St
Moscow ID 83843
Telephone: 208-882-2011
Fax: 208-883-1853
Medical Records Fax:
208-882-4651

Gritman MOSCOW FAMILY MEDICINE

Request for Release of Medical Records
**** PLEASE PRINT ****

Records To: **Moscow Family Medicine, PA** 623 S Main St Moscow ID, 83843 Ph: 208-882-2011 Fx: 208-883-1853

Records From:

MD or Group Name _____

Mailing Address _____

City, State, & Zip Code _____

Phone and Fax _____

Patient Info:

Name _____

Other (Maiden) Name _____

Date of Birth _____ **Last 4 of SS#** _____

Phone and Fax _____

Release Form/Delivery: ❒ Paper ❒ Electronic/CD ❒ Fax (Only if 40 pages or less) ❒ Mail ❒ Pick Up

PURPOSE OF RELEASE: ❒ Transfer of Care ❒ Personal Use ❒ Insurance ❒ Attorney/Legal request ❒ other

The information that I request to be released is:

❒ TRANSFER OF CARE: For transfer of care, records will be limited to patient demographics, chart summary, immunizations, last two office visits to include last physical, most recent lab reports, most recent EKG, recent imaging reports, most current colonoscopy report with pathology report, most recent echo, and op reports.
OR
❒ Pertinent info for the last 3 years (Chart summary, office visits, labs, imaging, other diagnostic tests)
Specific Reports/Record: ❒ Progress Notes ❒ EKG Reports ❒ Laboratory Results ❒ Imaging Reports ❒ Immunizations
OR
❒ Operative reports ❒ Consultation Reports❒ ER Reports ❒ Pathology Reports ❒ Other_____
OR
❒ Treatment dates from _____to _____ OR ❒ All Treatment Dates*Please verify with receiving physician's office the appropriate amount of records that they want and for what date range.*

I hereby request and authorize the release of requested health care information from the above-named party to the corresponding above-named party. This authorization will expire one year from the date signed below, unless I revoke it earlier. I may choose to revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by contacting Moscow Family Medicine in person or in writing to address above. Treatment, payment, enrollment nor benefit may be conditioned on signing the authorization.

I understand the information I authorize to be released may include information regarding STD's, HIV, Mental Health and drug/alcohol treatment and be subject to re-disclosure by the recipient. I understand that there may be a charge for this service, and I agree to pay said charge on demand.

_____ _____
Patient or Guardian Date

_____
If guardian, relationship