Request of Records Tracking Form

I, ____________________________, request Litchfield Family Practice Center, LLP to receive:

☐ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

To be disclosed, the following items must specifically be checked:

☐ Mental Health Treatment Records

☐ Alcoholism Treatment Records

☐ Drug Abuse Treatment Records

☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) records

☐ Laboratory Reports

☐ X-Ray Reports

☐ Operative Notes

☐ Genetic Testing

☐ Other: _______________________________________

Release From:

Healthcare Facility or Provider Name:
Address:
Phone Number:
Purpose:

Acknowledgement

1. I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
2. I understand that Litchfield Family Practice Center, LLP may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosed to a third party.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
4. I understand that this authorization is valid until it expires, unless revoked before that.

Request Made By:

Signature:
Patient Name:
Patient Date of Birth:
Relationship to Patient:
Date:

Litchfield Family Practice Center, LLP Witness:

Signature:
Printed Name:
Date: