***Release of Records Tracking Form***


I, _____, request Litchfield Family Practice Center, LLP to release:

☐ 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

☐ FMLA Forms

☐ Other: _____

***Release To***

| | |
|---|---|
| Healthcare Facility, Provider Name or Employer Name: | |
| Address: | |
| Phone Number: | Fax 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.
5. I understand that I may revoke this authorization at any time by giving written notice to Litchfield Family Practice Center, LLP of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where Litchfield Family Practice Center, LLP has already relied on it to use or disclose my health information. Written revocation must be sent to Litchfield Family Practice Center, LLP.

***Request Made By:***

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

Litchfield Family Practice Center, LLP Witness:

| |
|---|
| Signature: |
| Printed Name: |
| Date: |