

**REQUEST FOR RELEASE OF MEDICAL RECORDS
TO EAST BAY FAMILY PRACTICE MEDICAL GROUP, INC**

JANET ARNESTY, MD ♦ STEVE BRYZMAN, PA ♦ AUDREY D'ANDREA, MD ♦ SARAH WHITE, NP ♦ Caroline Schreiber, MD
REBECCA RISEMAN, NP ♦ EDIE SILBER, NP ♦ POLLY YOUNG, MD ♦ SARAH LOWENTHAL, MD ♦ SHARON HEALY, OFFICE MANAGER

This form is used to request medical records from another medical practice to EBFP.
Give this form to the office you are requesting records from.

✓ Patient's Name: _____

✓ I hereby authorize _____
Physician or Facility Name *(please print)*

Address City State Zip

to disclose my Protected Health Information (PHI) in the manner described below to East Bay Family Practice. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

✓ This authorization covers the following category of PHI: *(please check at least one)*

- Medical Records Claims/Billing Information
 HIV Test Results Other _____

✓ This authorization covers the following amount of PHI: *(please check at least one)*

- Entire PHI in the chosen category *(Example – All HIV Test Results)*
 Please limit use and disclosure of my PHI to: _____
(Example – Medical records from January 2001 to present)

✓ I authorize my PHI to be used and disclosed: *(please check one)*

- For continuity of care At my request
 For _____
(Specify purpose)

✓ This authorization will expire will automatically expire one (1) year from the date of execution unless a different end date or event is specified: _____ *(specify date or event)*

 PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

✓ Please mail/FAX this Protected Health Information (PHI) to:

**Janet Arnesty, MD ♦ Steve Bryzman, PA ♦ Audrey D'Andrea, MD ♦ Sarah White, NP ♦
Caroline Schreiber, MD ♦ Rebecca Riseman, NP ♦ Edie Silber, NP ♦ Polly Young, MD ♦
Sarah Lowenthal, MD ♦ Sharon Healy, Office Manager
East Bay Family Practice Medical Group, Inc
3100 Telegraph Avenue, Suite 2109
Oakland, CA 94609
Phone 510-645-9900 FAX 510-645-9919**

I understand that East Bay Family Practice Family Practice Medical Group, Inc will protect my Protected Health Information in accordance with HIPAA compliant East Bay Family Practice Medical Group, Inc Privacy Practices. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying you in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by you in reliance on this authorization before you receive my request for revocation or modification.

Notice of charges:

Requesting your medical records from another office may result in copy fees. That office determines this fee, and East Bay Family Practice cannot dispute the charges. Please check before requesting your records for any cost you may incur.

✓ Patient's Name (Print): _____ Date of Birth: _____
✓ Patient's Signature: _____
✓ Date: _____ SSN _____

If not signed by the patient, please indicate relationship:

- Parent, guardian or caregiver of a minor patient.
- Guardian or conservator of an incompetent patient.
- Beneficiary or personal representative of a deceased patient.
- Other _____ (*specify*)