DOWD MEDICAL ASSOCIATES
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(*MUST* COMPLETE *ALL* SECTIONS 1-5)

Patient's Name: _____ Date of Birth _____

Contact Phone #: _____

1. **I authorize Dowd Medical to release healthcare information of the patient named above to:**

Name: _____

This information will be picked up by the individual named above with photo id

2. Purpose of Release: ☐Medical Care Coordination ☐ Legal Matter ☐ Insurance ☐ Personal ☐*Transferring Care ☐ Other

*If Transferring Care Reason: Check all that apply
☐ Insurance change ☐ Moving/Planning to move ☐ Location/ closer MD
☐Transfer to Adult Care
☐Other * NEW Primary Care Physician_____

3. This request and authorization applies to:

☐Healthcare information relating to the following treatment, condition, or dates:

_____

☐Abstract (Includes Immunizations, 2 yrs of Office Visits, Specialists Notes and Labs, 5 yrs of Radiology reports)

4. ***Privileged or Specifically Protected Information. Please circle YES or NO for each of the following.**

If you had testing, diagnosis, or treatment for any condition listed below it is required that you release the information by signing below to authorize the type of information to be released. Even if you do not have the conditions listed below, Please address each line. The physicians at Dowd Medical believe that all information should be forwarded to a new provider to ensure the best care.

Yes/No -Behavioral/Mental Health (including ADD/ADHD) Yes/No- Alcohol/Drug Abuse
Yes/No-HIV,AIDS, STD Results/Treatment Yes/No- Domestic Violence
Yes/No -Rape/Sexual Assault/Pregnancy/Abortion Yes/No- Genetic Testing

Signed _____

5. Patient Signature: _____ Date Signed: _____
(Guardian if under 18 years of age)

For office use:
☐ Chart copied ☐ Given to Nurse/MA_____ ☐ Given to PCP _____ ☐ PCP signed _____
☐ Called patient ☐ Picked up (Date _____) ☐ Scanned release
Patient/ Authorized Representative Identification Verified by _____