THRIVE ADULT PRIMARY CARE, PC
AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION	Name:_____ Date of Birth:_____ Address:_____ Phone: (_____)_____ City:_____ State:_____ Zip:_____
Clinic/Hospital/Health Care Provider (Who has the information you want released?) List the specific Hospital and/or Clinic.	Name:_____ Fax: (_____)_____ Address:_____ Phone: (_____)_____ City:_____ State:_____ Zip:_____
Receiving Party (Where do you want the information sent? Who may have the information?)	Name:_____ Fax: _____ Address:_____ Phone: _____ City:_____ State:_____ Zip:_____
Information to be Released (What do you want sent or released? Check the appropriate box.)	Routine Record Sets (indicate date(s) of service _____) ☐ **Any and all records** (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.) ☐ Clinic (complete physical, office visits, lab, radiology, medicines, immunizations) ☐ Hospital (history and physical, discharge summary, operative report, consultations, emergency, labs, radiology) ☐ Billing Records ☐ Copies of Films/Images Only records types checked below: ☐ Discharge summary/note ☐ Radiology reports ☐ Emergency record(s) ☐ Medication records ☐ History & physical exam ☐ Rehab records (PT/OT/ST) ☐ Immunization/allergy record ☐ Chemical dependency/Substance abuse records ☐ Operative report ☐ Laboratory reports ☐ Pathology reports ☐ Consultations ☐ Progress notes/clinic notes ☐ Mental health records ☐ Pathology slides/blocks ☐ Other records specify record type(s) _____ _____ OPTIONAL Limits - Disclose only records related to following: Date(s) of service/:_____ injury or illness: _____
Release Instructions (How and When do you want the information?)	Date information is needed: _____ (NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING) Release Method / Format requested: (check one) ☐ Fax to Receiving Party ☐ Mail to Receiving Party
Purpose of Release (Why is it needed?)	☐ Continuing care ☐ Transfer of care ☐ Social security appeal ☐ Insurance application* ☐ Personal use or review * ☐ Social security/disability determination ☐ Insurance payment/claim ☐ Litigation/legal * ☐ Other* _____ * Fees may be charged by Provider from whom records are being requested

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Thrive Adult Primary Care, PC ("Thrive APC") Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- Thrive APC will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Thrive APC records may include records that it received from other organizations. If these records have been used by Thrive APC and filed in the record Thrive APC maintains about you, these records may be released with your Thrive APC records.
- Thrive APC cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Thrive APC from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above

_____ _____ _____
Signature of Patient/Legal Guardian Date Signer's Relationship to Patient (Documents attached)