Grand Primary Care

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Consent to Release Medical Information

Patient's Name	**Date of birth**

Release information from/to as follows:

From: _____ **To:** Grand Primary Care
(previous primary care provider)

_____ **To:** Grand Primary Care
(specialist office)

Specific information to be disclosed:
(X) Entire medical record
OR
( ) Progress Notes ( ) Test/procedure Results
( ) Other: _____
( ) Please include records from _____ to _____

How would you like to receive or send these records?
(X) Fax (833) 974-5242

Purpose for release:
(X) Transfer of care to another provider/practice
( ) At the request of the patient/legal representative
( ) Other: _____

I understand that once this information is released it is no longer the responsibility of this office's privacy standards.

This release is effective for one (1) year from the date of execution; however, it may be revoked by me (patient) at any time by providing written notice to this office.

_____ _____
Patient Signature (or Legal Representative or Guardian) Date