AMY BRENNER, MD & ASSOCIATES

Requested by provider? Yes No
If yes, choose provider _____

Medical Records Release Authorization

Patient Name_____DOB_____

Information to be released: _____

_____

_____

Medical Records to be released _____
Amy Brenner MD & Associates
6413 Thornberry Ct.
Mason, Ohio 45040
Phone- 513-770-0787 Fax- 513-770-0144

Medical Records to be released _____

Name_____

Address_____City_____State_____

Phone_____FAX_____Email_____

Your privacy is very important to us and email is not our preferred way of communication. Please ask us about signing up for a secure online patient portal for a secure as a safe option of receiving your medical records.

Reason for release:

_____ Personal Copy

_____Other

_____Transfer of health care provider.

We are continually striving to improve our practice and how we care for patients. We welcome feedback on your experience. If you would please inform us as to the reason for your decision to change your care provider, we would greatly appreciate it.(Please list in the area below.)

_____

_____

_____

□ **I understand my medical records contain private information.**
□ **I understand by authorizing this release of health records, the health care provider providing the records is no longer responsible for the confidentiality of such records.**
□ **I understand that I am unable to revoke authorization for the release of the records once they are released. I can revoke authorization for the future releases.**
□ **I understand fees MAY apply for the release of my records (i.e. entire chart).**
□ **Any charges accrued, as a result of the release of records, is the patient's sole responsibility.**

Signature of Patient_____Date_____