



A.A. Specialty Health Center
 A.A. Pain Clinic
 A NewLife Clinic
 NorthernNights Sleep Clinic

**PATIENT RECORDS
 REQUEST/RELEASE CONSENT FORM**

NAME: _____ **DATE OF BIRTH:** _____

DATE: _____ **PHONE #:** _____

DATE NEEDED: _____

How will you receive your records? Check one:

- PICK UP
- MAIL ADDRESS: _____
- FAX FAX #: _____

HIPPA laws mandate that we only release records that are specifically requested. Please check all that you wish us to disclose:

- ___ Office Notes ___ Radiology ___ All Records
- ___ Medications ___ Procedures ___ Other (Please specify below)
- ___ Labs ___ Hospital _____

Specify Dates of Service Needed: _____

I, _____, hereby grant permission to disclose all medical treatments, therapies, exams, x-rays, treatment plans, bills, personal payments, and insurance reimbursements to: _____.

I agree to release, hold free, harmless, and indemnify A.A. Specialty Health Center and its physicians, practitioners, and employees, from any claims, suits for damages or complications which may occur related to my case.

Please forward a copy of all my medical records and insurance records *within 30 days* of this request. ***I am aware that the first copy of my records is free per year. Additional copies are \$25.00 each.***

 Client's Printed Name

 Today's Date

 Client's Signature

 Witness's Signature

 Guardian's Signature

 Witness's Printed Name