

Gregory A. Hogle, D.O.

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Please print legibly

Patient: _____ Date of birth: ____/____/____

Address: _____ Phone: _____

I request that my medical records in the possession of Dr. Hogle be released to:

Patient directly: Mailing address indicated above OR Patient Portal Account

Patient Email _____

Physician/Clinic: _____

Mail to Address: _____

OR

Fax to #: _____ Phone #: _____

Information to be Released:

- All records
- Hearing test(s)
- Clinic Notes
- Imaging Reports
- Pathology Reports
- Other: _____

Dates of Treatment:

- All
- Specific Dates: _____

1. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records indicated above.
2. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may write a letter to Dr. Hogle.
3. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
4. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
5. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

Patient, Parent of Minor Patient, or Legal Guardian Signature

Date

Signature of Witness

Date