Complete
Family Medicine
A service of Hannibal Regional

MEDICAL RECORD REQUEST (to CFM)

This form must be completed **in full** before records can be requested and processed.

Patient Name: _____ Date of Birth: _____

SSN: _____ Phone #: _____

I authorize Complete Family Medicine, LLC to obtain records/information from the following Doctor or Organization:

Full Name of Doctor or Organization _____

Attention To _____ Phone # _____ Fax # _____

Address, City, State, Zip:_____

The purpose for which this disclosure is being made is for Continuity of Care

Date(s) of Service: _____

The type of information to be used by or disclosed to Complete Family Medicine, LLC is as follows (mark through anything you wish to **NOT** be disclosed, otherwise the entire record will be sent):
Face Sheet, Registration Sheet, Referral Sheet, Discharge Summary, ER Record, H&P, Consults, Progress Notes, Discharge Instructions, Lab Results, Radiology Results, EKG/Cardiology Testing Results, Operative Report, Implant Information, Pathology Report, Medication list, Behavioral Health Information, Substance Abuse Information, Human Immunodeficiency Virus (HIV) Information, Entire Record, Home Care Records, other: _____

I understand that if my authorization includes Behavioral Health, Substance abuse or HIV information, it may include; (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) – related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact)Section 7100.133); (ii) Substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and Alcohol abuse control act of 1972 – act 148 section 7(e); (iii) behavioral health information services.(Mental Health Procedures Act 1976, section 5100.3-39).

The information identified above is to be mailed to:
Complete Family Medicine, LLC
P.O.Box 293
Kirksville, Missouri 63501
Phone 660-665-7575

Please do not fax records/information over 25 pages, unless specified.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I understand if the Doctor/Organization that I request records from charges CFM for my records, I will be responsible for the entire amount of that bill. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient OR Legal Representative Date

_____ _____
Signature of Witness Date

PRIVILEGED AND CONFIDENTIAL

The attached information is intended only for the use of the addressee(s) named above. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient(s), please note that any dissemination, distribution or copying of this communication is strictly prohibited. Anyone who receives this communication in error should notify us immediately by telephone and return the original message to us at the above address via the U.S. Postal Service.

__Justin Puckett, DO __John Collins, DO __Jordan Palmer, DO __Aurora Bell, DO __David Spencer, DO __Maura Gerdes,DO
__Philip McIntire, DO __Julie Ladd,FNP __Stephanie Robinson, FNP-C __Courtney Nichols, FNP-C __Katie Sternberg FNP-C__Amy Linss, FNP-BC
__Thomas Bragg, DO__Rebecca Gibson, FNP__Sheila Oliver, FNP__ Alice Davis, FNP__Terri Tucker, WHNP__Ann Bibbs FNP
__G. Michael Early, DO __Gail Calvert,FNP __ Shelly Collins,FNP__ Sarah Ernst,FNP__ Andrew Wright, DO__Kelly Burchett, DO
__ Nola Moore, FNP __ Cari Blackburn, FNP __ Mary Crawford, DO__Kim Mitchell, FNP __Ayaaz Habibullah, MD