Medical Records Transfer Form

If you would like your medical records transferred between Pacifica Medicine & Wellness and another physician, please complete this form and submit it to Pacifica. Please complete one form for each physican's office from/to which you would like your records transferred.

Patient Authorization

Last name: First name: MI: DOB: [ ] Male [ ] Female

Home address: City: State: Zip:

Records to be sent FROM/TO: (circle intended direction)

Name: Phone: ( ) Fax: ( )

Address: City: State:

Records to be sent TO/FROM : (circle intended direction)

Name: **Pacifica Medicine & Wellness** Phone: **(360) 979-0569** Fax: ( )

Address: **19980 10th Ave. NE, Suite 202** City: **Poulsbo** State: **WA**

Purpose of Disclosure

[ ] Continuing care [ ] Insurance [ ] Legal [ ] Personal Use [ ] Transfer of Care

[ ] Other (please specify):

Records to Include

This authorization pertains to the disclosure of the record types indicated below for the past ________ years *or*
[ ] ALL records retained by the facility

[ ] Progress Notes [ ] Laboratory results [ ] Immunization Records [ ] Operative reports

[ ] Hospital Records [ ] Imaging Reports [ ] Other specified information:

Disclosure of Sensitive Information

I understand that my health record may contain sensitive information related to my condition(s). This includes, but is not limited to, information pertaining to sexually transmitted disease, HIV/AIDS, behavioral or mental health services and treatment for alcohol and drug abuse.

By checking this box, I chose to *exclude* the above types of information from this disclosure. [ ]

Terms & Conditions

* *I have the right to revoke this Authorization, in writing, at any time by notifying Pacifica Medicine & Wellness and the healthcare provider being requested to disclose the health information (if applicable). Such revocation will not apply to information that already been disclosed in reliance on this Authorization*
* I have the right to not sign this Authorization. Pacifica Medicine & Wellness will not condition treatments, payments for services, or enrollment or eligibility for benefits on whether or not I sign this Authorization.
* If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
* I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
* Please note, this Authorization expires one (1) year after the date of signature unless otherwise specified: _______________
* I understand that submitting this Authorization to Pacifica Medicine & Wellness with not terminate my membership and that I will continue to be billed for services until I submit a Service Cancellation Form to Pacifica Medicine & Wellness.

ACCOUNT HOLDER SIGNATURE: ____ **DATE: / /**

PRINT NAME: ________________________________ **SIGNATURE BY: [ ] Patient [ ] Parent [ ] Legal Guardian**