HICKORY MEDICAL

DIRECT PRIMARY CARE, LLC

Release of Records

Patient Name: _____ Date of Birth: _____

1: I hereby authorize and request: (Sender of information)

_____

_____

_____

To Permit: (Recipient of Information)

Hickory Medical Direct Primary Care

208 West Columbus Avenue

Bellefontaine, Ohio 43311

to release/disclose the above named individual's health information. I understand that the information in my record may include information pertaining to HIV/AIDS, AIDS-related conditions, sexually transmitted diseases, drug/alcohol abuse, and mental health.

I understand that by signing this authorization, I am authorizing the release of such information unless otherwise specified. The sender is authorized to deliver such information in person, via US Mail, private delivery service, facsimile or electronic transmission.

I understand that information forwarded via these methods may be viewed by someone other than the intended recipient.

Furthermore, I hereby release the sender from any liability that may result from the recipient's use, or further dissemination of the information sent. I understand that if the person or entity that receives this information is not a health care provider, or health plan covered by Federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the Federal privacy regulations.

2: In particular, without intending to limit the above authorization in any way, I am requesting the following information to be released: Full Record

3: The purpose of the authorized use or disclosure of the information is permanently transferring records to another physician as of the date ☐ January 1, 2016 ☐ March 1, 2016 ☐ _____

This consent will expire one hundred twenty (120) days after the date below unless otherwise specified. I understand I may revoke this authorization in writing at any time, except to the extent already taken by the sender in reliance on this authorization, by sending a written revocation to: Office Manager, Hickory Medical DPC. I understand this 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 I am not required to sign this authorization and Hickory Medical DPC will not condition the provision of treatment, or other benefits to me, on the signing of this authorization.

Dated: _____

_____

Signature of Witness (Required)

_____

Signature of Patient (18 years or older)

_____

Signature of Parent/ Legal Guardian
Next of Kin/Administrator of Estate