



PATIENT REQUEST FOR MEDICAL RECORDS TRANSFER FOR INFUSION IN PROGRESS
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION
PATIENT NAME DATE OF BIRTH
ADDRESS STREET CITY STATE ZIP CODE

I have been a patient of your office/facility (or am the patient's authorized representative) and I understand that the practice/facility provider has legally protected health information about me (or the person I represent) that I wish to transfer.

PROVIDER THAT HAS YOUR RECORDS

I, _____ hereby authorize the provider to provide a copy of my records:
PROVIDER NAME
ADDRESS STREET CITY STATE ZIP CODE
PHONE FAX

PROVIDER YOU WANT TO RECEIVE YOUR RECORDS

PROVIDER NAME Pace Healthcare LLC (for infusion care)
ADDRESS 5225 Cleveland Rd Ste F CITY Wooster OH 44691 PHONE 330-625-4900 FAX 330 685 9355

Medical records to be release: (please check all that apply)

- Original Infusion Order
Recent infusion notes
Prior authorization information
Current Medication List

By signing below, I acknowledge that: I may revoke this authorization in writing, but it will not affect disclosures/transfers already in progress made with this authorization

- I may refuse to sign this authorization, and my treatment may not be conditioned on my signing of this form, unless the purpose of my treatment is disclosure to a third party (for example, a drug test for employment)
I can receive a copy of this authorization upon request
A photocopy or scanned image of this authorization may be used in lieu of the original
I understand that recipients may not be subject to federal law and disclose information which I have authorized them to receive

Signature: _____ Date: _____

If signed by a personal representative of patient, print name and relationship to patient:

Name: _____ Relationship: _____

Please attach a copy of documentation of personal representation, e.g., Power of Attorney, Legal Guardianship.

Please Mail Completed form to Pace Healthcare LLC 5225 Cleveland Rd Ste F Wooster OH 44691 or fax to 330-685-9355