MEDICAL RECORDS TRANSFER FORM

If you would like your records transferred between Gateway Urgent Care and another medical office, please complete this form and submit it to our office. Please complete one form for each office to/from which you would like records transferred.

Patient Authorization

Last Name ____________________________________ First Name __________________________________ MI _______

Date of Birth ___________________________________ □ Male □ Female

Home Address ____ City ____________________ State __________ Zip __________

From/To (Please circle intended direction)

Name ____

Address ____ City ____________________ State __________ Zip __________

Phone ____ Fax _______________________________________

From/To (Please circle intended direction)

Name Gateway Urgent Care, 1574 Medical Center Pkwy #104, Murfreesboro, TN 37129

Phone (615) 225-2070 Fax 615-962-9047

Purpose of Disclosure

□ Transfer of Care □ Continuing Care □ Insurance

□ Legal □ Personal Use □ Other (please specify) ______________________

Records to Include

This authorization allows for disclosure of the following record types for the date range of _________ (mo/yr) to _________ (mo/yr)

□ All Records □ 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 relating to patient's conditions. This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental services and treatment for alcohol and/or drug abuse.

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

Terms and Conditions

- I have the right to revoke this Authorization, in writing, at any time by notifying Gateway Urgent Care. Such revocation will not apply to information that has already been disclosed in reliance of this Authorization.
- I have the right to not sign this Authorization. Gateway Urgent Care will not condition treatments, payment for services or enrollment or eligibility for benefit on whether I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is 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 the 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 Gateway Urgent Care will not terminate the patient's relationship to the practice.**

Signature ______________________________________ Date ________________________

Printed Name ___________________________________

Signature by: □ Patient □ Parent □ Legal Guardian