NCH HEALTHCARE GROUP
(NCHHG)

REQUEST FOR THE RELEASE OF MEDICAL RECORDS

TO NCH HEALTHCARE GROUP

By signing this authorization, I authorize NCHHG to obtain my medical records (or the records for my minor children) from a non-NCHHG provider listed below.

FROM:

____
Name of non-NCHHG Provider or Facility **(REQUIRED)**

____
Address **(REQUIRED)**

____________________ ____________________
Phone Number **(REQUIRED)** Fax Number (if available)

Using the space below, specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.

____
____
____

or

☐ Check here if you need the entire medical chart sent to your NCH HEALTHCARE GROUP physician.

This release is for the purpose of the continuity of my health care. I would like the records transferred **TO:** ______________________________
(indicate the name of the NCHHG physician to which records are to be sent)

Please check one:

☐ Mail or fax the records to the NCHHG physician above at the following address/fax:

____________________ ____________________
Address of NCHHG Medical Office **NCHHG Fax Number**

or

☐ I, as the patient, will pick up the records and transfer them to my NCHHG physician.
When the records are ready for pickup, phone me at: ____________________

Signed by: ____________________ ____________________
Signature of Patient or Legal Guardian Patient's Date of Birth

____________________ ____________________
Print Patient's Name Today's Date

____________________ ____________________
Print Name of Legal Guardian Relationship to Patient

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