GLASS MEDICAL

AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS

I authorize _____to disclose my medical records to **GLASS Medical, 2011 East 32nd Street, Suite 101, Joplin, Missouri**, for continuation and transfer of my medical care at my request. The secure delivery address, fax number, or electronic destination for GLASS Medical will be provided to _____when available.

Information authorized for release: My complete medical record maintained by_____ _____, including but not limited to office and progress notes, medication lists, problem lists, laboratory and imaging results, referrals and consultation records, immunization records, procedure records, hospital or outside records maintained in my chart, and other treatment records that are part of my medical record. This authorization does not include psychotherapy notes or other records that require a separate authorization under applicable law unless separately authorized.

Purpose: Continuity and transfer of medical care at my request.

Expiration: This authorization expires one (1) year from the date I sign it or upon completion of the requested transfer of my records to GLASS Medical, whichever occurs first.

I understand that:

- Signing this authorization is voluntary.
- My current or future treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on signing this authorization, except as permitted by law.
- I may revoke this authorization at any time by submitting a written revocation to_____. Revocation will not affect any disclosure already made in reliance on this authorization.
- Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient as permitted by applicable law and may no longer be protected by HIPAA if disclosed to an entity that is not subject to HIPAA.
- I am entitled to a copy of this signed authorization.

Patient Name:	**Date of Birth:**
Patient/Legal Representative Signature:	**Date:**

If signed by a legal representative, relationship/authority: _____

Patient phone (optional): _____