Medical Records Transfer Form

Qliance
Primary Care Specialists

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

Patient Authorization

Last Name:	First Name:	MI	DOB: *mm/dd/yyyy*	O Male	O 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: **Qliance Medical Group of WA**			
Address: **999 Third Avenue, Suite 810**	City: **Seattle**	State: **WA**	Zip: **98104**
Phone: **(206) 913-4700**	Fax: **(206) 913-4710**		

Purpose of Disclosure

☐ Continuing Care	☐ Insurance	☐ Legal	☐ Personal Use
☐ Transfer of Care	☐ Other (please specify):		

Records to Include

This authorization pertains to the disclosure of the record types indicated below between the following dates of service: **from _____ to _____** OR ☐ **ALL records retained by facility.**

☐ Progress notes	☐ Laboratory notes	☐ 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 my condition(s). This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental health services and treatment for alcohol and drug abuse.

By checking this box, I choose to exclude the above types of information from this disclosure. ☐

Terms & Conditions

- I have the right to revoke this Authorization, in writing, at any time by notifying the Privacy Office at Qliance and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that already had been disclosed in reliance on this Authorization.
- I have the right to not sign this Authorization. Qliance will not condition treatments, payment for services or enrollment or eligibility for benefits 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 the 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 an 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:_____

SIGNATURE: **DATE:**

PRINT NAME: **SIGNATURE BY:** O Patient O Parent O Legal Guardian