TridentCare

Please complete and return to Medical Records via fax to 484-398-7210 or via email to medicalrecords@tridentcare.com.

Section A – Patient Information (individual whose information will be released):

Patient Name: (Last, First, Middle Initial, Title)	**Date of Birth:** MM/DD/YYYY

Section B – Authorized Person (person(s) or organization to receive patient's information)

_____

_____

(Please include the name, address, email address, and phone number of the person(s), category of persons or organization to whom the patient's information will be sent)

Section C – Information to be Released: (type of information to be sent).

1. **Description of the Information to be Disclosed**: (Type of information that will be released. Please check only the types of information that apply to this request)

☐ X-ray Images ☐ Ultrasound Images ☐ Lab Results ☐ Radiologist Report

☐ Medical Record ☐ Other: _____

2. **Date(s) of Treatment and/or Service related to the Information to be Disclosed**: (Specify the date or range of dates that TridentCare provided treatment or service(s) to the patient related to the requested information).

From: To:

Section D – Method of Delivery

☐ Sharing Apps: ☐ Ambra (*please share an upload link*) ☐ PowerShare (*Hub accounts only*)

☐ Email: _____ (email address)

☐ Fax (reports only): _____(fax number)

☐ CD / USB via FedEx (circle one, please include a phone number for tracking)

☐ PACs Transfer (**ONLY** to be completed by provider with an existing PACS connection)

Section E – Treating Physician's Signature: (please sign and date this certification)

I, the undersigned, certify that the above-named patient is under my care and the records being requested are pertinent to treatment and coordination of care or for another HIPAA-compliant purpose. Additionally, if required by applicable state or federal law, the patient and/or responsible party have provided consent to the release of information for continued treatment or other HIPAA-compliant purpose.

Signature of Physician or Authorized Clinical Staff:	**Date:** (MM/DD/YYYY)

Physician or Organization Printed Name and Address: