



OLIVE TREE 1 CARE

MEDICAL RECORDS REQUEST & AUTHORIZATION

Use this form to request records be sent to Olive Tree 1 Care or to authorize Olive Tree 1 Care to release records. Complete all applicable sections. Incomplete forms may delay processing.

1 PATIENT INFORMATION

Patient full legal name

Preferred name

Date of birth (MM/DD/YYYY)

Phone number

Email address

Street address

City, State, ZIP

Medical record / patient ID (if known)

2 DIRECTION OF REQUEST

- ☐ REQUEST: I authorize the provider/organization listed below to send records TO Olive Tree 1 Care.
- ☐ RELEASE: I authorize Olive Tree 1 Care to send records TO the person/organization listed below.
- ☐ PATIENT COPY: I request a copy of my Olive Tree 1 Care records for myself or my legal representative.

3 PROVIDER OR ORGANIZATION SENDING / RECEIVING RECORDS

Provider / organization name

Contact person or department

Phone

Fax

Secure email

Street address

City, State, ZIP

Relationship to patient

Olive Tree 1 Care delivery destination: Secure patient portal or another secure method coordinated through www.olivetree1care.net.



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4 INFORMATION AUTHORIZED FOR DISCLOSURE

Date range — From

To

☐ All dates of service

- | | |
|--|---|
| ☐ Diagnostic / intake assessment | ☐ Discharge / transfer summary |
| ☐ Treatment plans and updates | ☐ Care coordination and referral records |
| ☐ Progress notes / clinical summaries | ☐ Laboratory or diagnostic results maintained in the chart |
| ☐ Psychiatric evaluation | ☐ Billing / claims records |
| ☐ Medication list and medication-management records | ☐ Entire medical record (psychotherapy notes excluded) |

Other records

SPECIAL RECORDS — TYPE YOUR INITIALS TO AUTHORIZE

Substance-use-disorder records protected by applicable federal law, including 42 CFR Part 2

HIV/AIDS-related information, including testing and treatment information

Genetic testing or genetic-counseling information

Other specially protected information

Psychotherapy notes notice: Psychotherapy notes are maintained separately from the medical record and generally require a separate, specific authorization. Selecting 'entire medical record' does not authorize their release.

5 PURPOSE OF DISCLOSURE

- | | |
|---|---|
| ☐ Treatment / continuity of care | ☐ Legal matter |
| ☐ At the request of the patient | ☐ Care coordination / referral |
| ☐ Insurance, benefits, or disability determination | ☐ Other purpose |

6 PREFERRED DELIVERY METHOD

- | | |
|--|--|
| ☐ Secure patient portal | ☐ Mail |
| ☐ Encrypted email | ☐ Patient pickup / patient copy |
| ☐ Secure fax | ☐ Other secure method |

Format:

☐ Electronic/PDF

☐ Paper

☐ No preference



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7 AUTHORIZATION, EXPIRATION, AND PATIENT RIGHTS

- I authorize the use or disclosure of the information described in this form to the person or organization identified above.
- I understand that signing is voluntary. Olive Tree 1 Care will not condition treatment, payment, enrollment, or eligibility for benefits on signing, except where permitted by law.
- I may revoke this authorization in writing at any time. Revocation will not affect actions already taken in reliance on this authorization.
- Information disclosed under this authorization may be subject to redisclosure and may no longer be protected by HIPAA. Records protected by 42 CFR Part 2 remain subject to applicable federal confidentiality protections.
- I may receive a copy of this signed authorization. Fees permitted by applicable law may apply; I will be notified before charges are incurred.
- I certify that the information is accurate and that I have authority to sign if I am acting as the patient's personal representative.

☐ Authorization expires one year from date signed

☐ Earlier date

Earlier date

Expiration event (optional)

8 SIGNATURE

Patient or personal representative signature / typed e-signature

Date signed

Printed name of signer

Relationship to patient

Representative authority (attach documentation if requested)

Witness / staff member (optional)

For a minor or person lacking legal capacity: The signer affirms that they are legally authorized to act for the patient. Some records may require the patient's own authorization under applicable law.

9 OFFICE USE ONLY

Date received

Identity / authority verified by

Date completed

Method sent / received

Staff initials

Tracking / disclosure log reference

Questions or secure submission: www.olivetree1care.net or the Olive Tree 1 Care patient portal