CENTER FOR SELF-DEVELOPMENT
VIRGINIA BUKI, M.D., DFAPA, CPC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print

____
Patient Name | Other Last Names

____
Date of birth | Phone Number | Email Address

____
Street Address | City, State, Zip code

Transfer of care is required due to the closing of my physician's office. Therefore, I hereby authorize

Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103,

on behalf of Center for Self-Development, 2875 NE 191st St, Suite 700, Aventura, FL 33180 to execute one of the following;

Please select one of the following delivery options:

☐ Secure HIPAA approved electronic transfer to patient.
List your email address here ____

☐ Pick up disc, in person, at Morgan Records, 159 Frontage Road, Manchester, NH 03103. Available office hours are Monday – Friday 9am-5pm. **We will call once chart is processed to set up pick up time**

☐ Disc mailed to home or physician/facility. There will be a **$10 shipping charge prior to mailing**. We mail USPS Certified Return Receipt. List address here:

____

I, ____, am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to request my medical records. This form gives you permission to share my complete health records, including my private information, obtained from this facility. Only records from this facility can be legally released. Any records from other physicians must be obtained from them directly.
Normally psychotherapy notes are not sent unless specifically requested by the patient:
I authorize the release of my Psychotherapy Notes YES ______ NO ______

Please note; a $25 records management fee is requested to process & deliver your medical records.

Payment Options:

- **CREDIT CARD** –visit our website at MorganRM.Com, Medical Records tab, Request My Records
- **CHECK** - please mail your completed authorization form with an attached check or money order made payable to Morgan Records Management LLC, to 159 Frontage Rd, Manchester, NH 03103.

____
Patient or Legal Guardian Signature | Date

Your completed authorization form may be faxed to 603-509-3987, emailed to MHurley@MorganRM.com, or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.