

FAMILY CARE ASSOCIATES OF NEW CASTLE

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 **Family Care Assoc of New Castle, 3315 Wilmington Rd, New Castle, PA 16105** 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 _____

Disc mailed to home or physician. 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 forward my medical records. This form gives you permission to share 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.

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

Payment Options:

- **CREDIT CARD** – use our online form 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.

****Requests are processed in the order they are received and can take up to 30 business days****

Patient or Legal Guardian Signature

Date

Your completed authorization form may be faxed to 603-606-1126, emailed to MHurley@MorganRM.com, or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.