Authorization to Release Health Information

Method of Release: ☐ In Clinic ☐ Verbal ☐ CD ☐ Paper Fax (up to 60 pages)

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell/Day Phone: _____ Work Phone: _____

FROM: Please list the specific hospital, clinic, provider where the requested records are:

Clinic or Provider Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone Number: _____ Fax Number: _____

TO: Please list the specific hospital, clinic, provider or person who you want the records sent to:

Person/Clinic or Provider: _____

Address: _____ City: _____ State: ____ Zip: _____

Fax Number: _____ Day Phone: _____

Information – Check one item to release

☐ (Last 3 visits) Recent summary of care (include medication list, problem list, H&P, labs, notes of visits, etc.
☐ (Last 2 years) Summary of care to include medical list, problem list, H&P, labs, notes of visits, etc.
☐ Complete record set (all records) Patient Must Initial: _____
☐ Other (please be specific) _____

Sensitive – Please choose sensitive records you want released (must be checked or may not be included)

☐ HIV/AIDS
☐ Sexually Transmitted Diseases
☐ Substance Abuse
☐ Mental Health/Psychiatric Care
☐ Verbal exchange of information/coordination of care (specific to items located in this sensitive area)

Pursuant to 42 U.S.C. 290dd-2 (g), the regulations in this part impose restrictions upon the use and disclosure of substance use disorder patient records ("records," as defined in this part) which are maintained in connection with the performance of, if applicable, part 2 program.

1. Authorization is valid for one year after date signed unless you enter a different date or expiration here: Date: _____
2. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
4. I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal regulations.
5. A fee is charged for some copies of healthcare information and must be paid in advance.

******** By signing I consent to releasing the protected health information.**

_____ _____

Patient/Guardian/Power of Attorney Signature **Date**
Authority to Sign on Behalf of Patient (Proof Required)

Staff Use only (initial): _____ Verified all sections are complete: _____