

1) PATIENT INFORMATION:

Name _____ Address _____ City _____ State _____ Zip _____
Date of Birth _____ (_____) Daytime Phone _____ Previous Name _____

2) AUTHORIZES:

Name of Health Care Provider / Plan / Other _____
Address _____

3) TO DISCLOSE TO: [] Self, Delivery Options: [] Pick up [] View on Site [] Mail to address above [] Electronic Format: _____
[] To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)
[] Send to: _____
Name of Health Care Provider / Plan / Other _____
Address _____ Or _____
Health Care Provider FAX # _____
Recipient (Contact) Phone Number: (_____) _____

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____ If left blank, only
information from the past two (2) years will be disclosed. (month/year) (month/year)

5) INFORMATION TO BE DISCLOSED: [] Verbal [] Written
[] Billing Records related to (specify): _____ [] Immunizations
[] Emergency Department Reports [] Lab Reports
[] Hospital Summary – a general abstract will be sent which includes Discharge Summary, H&P, Consults, Operative Reports, Labs, Radiology Reports & ER. [] Procedure Op Reports
[] Imaging Films (X-ray) [] Progress Notes/Updates
[] Imaging Results [] Other: _____

I understand that the information to be disclosed may include information regarding genetic testing, and mental illness, alcohol/drug abuse, HIV Test results, AIDS/AIDS related illness, and developmental disabilities. We will disclose such information, unless you indicate below that you do not want such information disclosed:

[] Alcohol/Drug Abuse [] HIV Test Results [] Mental Health/Developmental Disabilities [] Genetic Testing

6) EXPIRATION: This Authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) PURPOSE (Check all that apply - copy fees may apply)
[] Further Medical Care – no fee [] Insurance Eligibility/Benefits – fee \$ [] Legal Investigation /Action – fee \$
[] Personal (at my request) - possible fee \$ [] Forms Completion - possible fee \$ [] Other: _____ (specify)

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) SIGNATURE OF PATIENT / LEGAL REP: _____ DATE: _____
If signed by a person other than the patient, complete the following:

- 1. Individual is: [] a minor [] legally incompetent or incapacitated [] deceased
2. Legal authority: [] parent* [] legal guardian [] next of kin / executor of deceased [] activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only: Signature/ID verified [] Yes [] No Completed by: _____ # of pages released _____
Name / Date

