AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

Address: _____ Day Phone: _____

City: _____ State: _____ Zip: _____

Clinic/Hospital/Health Care Provider –

(***Who*** has the information you want released?) **Please list the specific Hospital and/or clinic.**

NAME: _____

Address: _____ Day Phone: _____

City: _____ State: _____ Zip: _____

Receiving Party

(***Where*** do you want the information sent? ***Who*** may have the information?)

NAME: _____ Attention to: _____

Address: _____ Day Phone: _____

City: _____ State: _____ Zip: _____

Fax Number: _____

Information to be Released

(***What*** do you want sent or released? Check the appropriate box.)

Routine Record Sets **(indicate date(s) of service _____)**

- ☐ Clinic (office visit, lab, radiology, medicines, immunizations)
- ☐ Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)

☐ Billing Records
☐ Copies of Films/Images
☐ Community Pharmacy Charges
☐ Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.)

Only records types checked below:

☐ Discharge summary/note	☐ Radiology reports	☐ Emergency record(s)	☐ Medication records
☐ History & physical exam	☐ Rehab records (PT/OT/ST)	☐ Immunization/allergy record	☐ Chemical dependency/ Substance abuse records
☐ Operative report	☐ Laboratory reports	☐ Pathology reports	
☐ Consultations	☐ Progress notes/clinic notes	☐ Mental health records	☐ Pathology slides/blocks

☐ Other records specify record type(s) _____

OPTIONAL Limits - Disclose only records related to following:
Date(s) of service: injury or illness:

Release Instructions

(***How*** and ***When*** do you want the information?)

Date information is needed: _____

Release Method / Format requested: (check one)

☐ ***Paper*** ☐ ***CD/DVD*** ☐ ***View my Record*** ☐ ***Fax* (patient care only)** ☐ ***Verbal***

Continuing Care Information released by Nursing Station/Department (verbal and paper) ☐ **Yes** ☐ **No**

Purpose of Release

(***Why*** is it needed?)

☐ **Continuing care**	☐ **Transfer of care**	☐ **Social security appeal**
☐ **Insurance application**	☐ **Personal use or review**	☐ **Social security disability determination**
☐ **Insurance payment/claim**	☐ **Litigation/legal**	

☐ **Other** _____

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Above mentioned Hospital and/or clinic may include records that it received from other organizations.
- Above mentioned Hospital and/or clinic cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the above mentioned Hospital and/or clinic from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ Patient/Legal Guardian Signature

_____ Date

_____ Authority to act on behalf of patient (attach document)

_____ (Witness: Sign and print name)