AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Day phone: _____

I HEREBY AUTHORIZE _____ TO RELEASE INFORMATION FROM MY (OR THE PATIENT I REPRESENT) MEDICAL RECORD AS INDICIATED BELOW

TO:

Name: _____

Address: _____

_____

_____

<u>Specific description of information to be released</u> (check one):

- ☐ **All Medical Records (This includes all information in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurses' notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and record received from other provides.)**

- ☐ **All Medical Records AND Access to My Online Patient Portal (This includes all information in my records as described above, plus continuing access to my patient portal and all information in my patient portal).**

- ☐ **Only Access to My Online Patient Portal (This includes continuing access to my patient portal and all medical information available in my patient portal.)**

- ☐ **Limited Medical Records – must describe (including dates):**
  _____

I understand the information to be released may include information about: mental health conditions and treatment; alcohol or drug abuse testing and treatment; genetic information and family history; HIV or AIDS status, testing or treatment; and/or sexually transmitted disease testing treatment.

Purpose of Release:

☐ Consultation/second opinion	☐ Continuing Care	☐ Changing Physician
☐ Legal	☐ School	☐ Insurance
☐ Moving	☐ Other (please specify) _____	
☐ Access to Online Patient Portal		

Expiration Date: This authorization expires on _____ or within one year of the date signed if I have not provided an expiration date.

Request by the individual to receive own information: If I am requesting this information to be released to me (check one):

- ☐ I would like to receive the information in an electronic format through my online patient portal.
- ☐ I would like to receive the information in a different format if possible (specify: _____).

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity.

A photo copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient or Patient's Representative **Date**

Printed Name of the Patient's Personal Representative: _____

Relationship to the patient (including authority for status as representative):_____