

Authorization to Release and Disclose Protected Health Information

Patient Information	Patient Name: _____ Date of Birth: _____ Address: _____ Day Phone: _____ City: _____ State: _____ Zip: _____	
Clinic Health Care Provider (Who has the information you want released?) Please list the specific Provider and/or Clinic.	Clinic or Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Fax#: _____ Day Phone: _____	
Receiving Party (Where do you want the information sent?)	Name of Receiving Party: _____ Attention: _____ Address: _____ City: _____ State: _____ Zip: _____ Fax#: _____ Day Phone: _____	
Information to be Released (What do you want sent or released? Check appropriate box.)	<input type="checkbox"/> Designated Record Set (records including patient, demographics, health and billing records) – Last two (2) years. <input type="checkbox"/> Date of service or records related to a specific illness (specify date of service or illness): _____ <input type="checkbox"/> Any and all records in Designated Record Set – Patient Initials: _____ <input type="checkbox"/> Other (specify record type): _____	
Release of Sensitive Health Information	The health information released may contain Mental Health, Alcohol or Drug abuse, HIV or AIDS, Sexually Transmitted Disease, or Family Planning. Please check one of the following and initial to release or not release this sensitive information that may be contained in your record: Release: <input type="checkbox"/> or Not release: <input type="checkbox"/> Initials _____	
Purpose of Release (Why is it needed? Why do you want it?)	Health care: <input type="checkbox"/> Personal use: <input type="checkbox"/> Legal: <input type="checkbox"/> Insurance: <input type="checkbox"/> Other – Please specify: _____	
Release Instructions (How and When do you want the Information? Who do you want to pick up if not you and does CHC have valid documents on file?)	1. Release records by: a. <input type="checkbox"/> Paper <input type="checkbox"/> In person pickup <input type="checkbox"/> Mail to receiving party <input type="checkbox"/> Fax to receiving party <input type="checkbox"/> Fax number: _____ b. <input type="checkbox"/> CD/DVD <input type="checkbox"/> In person pickup <input type="checkbox"/> Mail to receiving party 2. If in person pickup, the person picking up the records is the <input type="checkbox"/> Patient <input type="checkbox"/> Parent/Family/Friend <input type="checkbox"/> Legal Representative (must have appropriate documents on file with CHC) 3. Verify identity of person picking up records: _____ 4. Name of person picking up records: _____ Relationship to patient: _____	
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. 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. 4. A fee is charged for some copies of healthcare information and must be paid in advance. 5. MINORS 13-17: A minors signature is required in order to release information regarding the following conditions: Reproductive care such as contraception, pregnancy (any age), sexually transmitted diseases (14 years and older), alcohol/drug abuse (13 years and older), and mental health (13 years and older). I consent to releasing the protected health information.		
_____ Patient/Guardian/Power of Attorney Signature	_____ Authority to Sign on Behalf of Patient (Document Required)	_____ Date
AUTHORIZATION TO REVOKE RELEASE OF INFORMATION: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: auto; margin-right: auto;"> _____ _____ </div> <div style="display: flex; justify-content: space-between; width: 80%; margin-left: auto; margin-right: auto;"> Patient Signature Date </div>		