Authorization to Release Health Records

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 you want to send the records	Clinic or Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____ Fax Number: _____
To Please list who you want to receive the records	Name of Person Receiving: _____ 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:** _____ ___ **(Last 2 years)** Dental X-Rays and/or summary of care **Complete** Dental record set (all): **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.
Consent - Minors	Minors ages 13 – 17 **must** provide authorization to release the sensitive information below (please initial beside records to release: _____ Contraception, family planning and pregnancy _____ Conditions related to HIV/AIDS (to include testing) (14 and older) _____ Alcohol/Drug abuse (13 and older) _____ Mental Health/Psychiatry (13 and older)

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 **Authority to Sign on Behalf of Patient (Proof Required)** **Date**

AUTHORIZATION TO REVOKE RELEASE OF INFORMATION: _____

Staff Use only (initial):
Verified all sections are complete: _____ I have completed all actions: _____