



Release of Records

| Section A: This section must be completed for all Authorizations | | | | | |
|---|----------|--|----------|--|-------------|
| Patient Name: | | Birth Date: | | Social Security No. (optional): | |
| Provider's Name: | | Recipient's Name: | | | |
| Provider's Address: | | Address 1: | | | |
| | | Address 2: | | | |
| | | City: | | State: | Zip: |
| This authorization will expire on the following: (Fill in the Date or the Event but not both.) | | | | | |
| Date: | | Event: | | | |
| Purpose of disclosure: | | | | | |
| Are you leaving the practice? Yes No | | | | | |
| If yes, reason for leaving the practice: | | | | | |
| Moving Change of Insurance Patient Deceased Dissatisfied w/ Provider? If so, why? _____ | | | | | |
| Other: _____ | | | | | |
| Description of information to be used or disclosed | | | | | |
| Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need. | | | | | |
| Description: | Date(s): | Description: | Date(s): | Description: | Date(s): |
| <input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets | | <input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information | | <input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: <input type="checkbox"/> Other: | |
| I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/> | | | | | |
| I understand that: | | | | | |
| 1. I may refuse to sign this authorization and that it is strictly voluntary. | | | | | |
| 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. | | | | | |
| 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. | | | | | |
| 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. | | | | | |
| 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. | | | | | |
| 6. I get a copy of this form after I sign it. | | | | | |
| Section B: Is the request of PHI for the purpose of marketing? | | | | | |
| If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C. | | | | | |
| Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If yes, describe: | | | | | |
| Section C: Signatures | | | | | |
| I have read the above and authorize the disclosure of the protected health information as stated. | | | | | |
| Signature of Patient/Patient's Representative: | | | | Date: | |
| Print Name of Patient's Representative: | | | | Relationship to Patient: | |