



RELEASE OF/REQUEST FOR HEALTHCARE INFORMATION

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE:(____) _____

RELEASE TO: FACILITY LISTED ABOVE -OR-

PRACTICE NAME: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE:(____) _____ FAX:(____) _____

RELEASE FROM: FACILITY LISTED ABOVE -OR-

INFORMATION TO BE RELEASED: (Check all that apply) ENTIRE RECORD ER NOTES
 CONSULT X-RAY/MRI/CT/US LABS/PATH H&P OP REPORT D/C SUMMARY
 EKG OFFICE NOTES OTHER _____

INCLUDING SENSITIVE INFORMATION: (*Required to be checked off individually in order to be released*)

MENTAL HEALTH ALCOHOL/DRUG USE/TREATMENT HIV DX/TX

DATES OF SERVICE TO BE RELEASED:

ALL MOST RECENT PAST 5 YEARS FROM: _____ TO: _____

HOW TO BE RELEASED:

PICKED UP MAILED FAXED (Read Release Below) OTHER _____

I am aware that the above requested information is to be released via a fax machine/press. I am also aware of the risks associated with faxing protected/sensitive health information including but not limited to: erroneous transmission, lack of confidentiality safeguarding at the site of receipt and incomplete transmission of information.

PURPOSE OF REQUEST: NEW PCP CONTINUED CARE LEGAL INSURANCE

PERSONAL WORK/AUTO OTHER: _____

UNDERSTANDINGS:

I understand that the information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information is subject to re-disclosure and may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time in writing or verbally, if followed by written confirmation.

There may be an administrative fee of \$15.00 for the first 1-30 pages and 50 cents per page thereafter.

I have read or have had this entire form read to me. I understand the content. I hereby authorize the release of my Private Health Information stated above and excuse the releasing party from any legal responsibility or liability relating to the release of information. This authorization is considered valid for a period of ninety days from the date of signature. The date of authorization may not precede the date(s) of service(s) being requested.

Patient/Parent/Legal Agent Signature _____ 20_____
Date

Relationship - Please Provide Legal Documentation if Necessary