

**Patient Information**

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Maiden or Other Names Used \_\_\_\_\_ Social Security Number: XXX-XX-\_\_\_\_ (last 4 digits)  
Address \_\_\_\_\_  
Day Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Release From**

Hospital/Clinic Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Release To**

Person/Company/Organization Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Purpose**

Continuation of Care  Insurance/WC  Legal  
 Personal  Other (specify): \_\_\_\_\_

**Date(s) Of Information To Be Released**

Date(s) of Service from \_\_\_\_\_ through \_\_\_\_\_  
Date(s) of Service from \_\_\_\_\_ through \_\_\_\_\_

**Information To Be Released/Accessed**

I would like copies of the items checked below for the treatment dates listed above.

Emergency Report  Discharge Summary  History & Physical  Imaging CD/Film (MRI/CT/X-Ray/Ultrasound)  
 Operative Report  Consultation  Laboratory  Imaging Report  
 Clinic Visit  Billing Records  Cardiac Studies/EKG  Other: \_\_\_\_\_

**Disclosure/Access Format**

I would like copies of the items checked above in the following format: (Paper format-US Mail is default if not marked)

Paper format - US Mail  CD  Fax (healthcare provider only)  
 Paper format - pick up  Review only  Email to: \_\_\_\_\_

**Patient Access Information**

- I will provide a picture ID prior to accessing my medical record.
- I may review my medical record without a charge. If I request copies of my medical record, I may be charged a fee.
- I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.
- A Care Site professional will supervise the review of my medical record.
- If I am involved in a research study involving medical treatment, my access to the research study content may be temporarily suspended for as long as the research is in progress. At the completion of the research, access to my medical record will be reinstated.

**I Understand That**

- The information to be released may include a diagnosis or reference to the following condition(s): *behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.*
- Without my express revocation, this authorization will automatically **expire** 180 days from the date signed below, unless I request an expiration date less than 180 days.
- I may **revoke** this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Information disclosed pursuant to the authorization may be subject to **redisclosure** by the recipient and is no longer protected by the HIPAA Privacy rule, unless the disclosure includes records from a federally-assisted program specifically providing diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case **redisclosure is prohibited** under 42-CFR Part 2.

My signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided. According to State Statutes, this care site may charge for copies of medical records.

Signature of Patient/Guardian/Personal Representative \_\_\_\_\_ Relationship (if not patient) \_\_\_\_\_ Date \_\_\_\_\_

Personal Representative's PRINTED Name, Address, and Phone Number \_\_\_\_\_

If patient is unable to sign, document reason: \_\_\_\_\_

**For Office Use Only**

Date Authorization Received: \_\_\_\_\_ By: \_\_\_\_\_ Identification/Driver's License # Verified: \_\_\_\_\_  
Date Received/Completed: \_\_\_\_\_ By: \_\_\_\_\_ Delivery Instructions: \_\_\_\_\_

**PATIENT INFORMATION**



are of Protected

Health Information (PHI)