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| Release of Medical Records Form | | | | |
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| **AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION** | | | | |
| Please complete **all sections** of this release of medical records form. If any sections are left blank, this form will be invalid. Use N/A if not applicable. | | | | |
|  |
| **1 - Patient Information** | | | | |  |
| Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Medical Reference Nº: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **2 - Individual/Organization Authorized by Signatory to Release PHI** | | | | |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **3 - Individual/Organization Authorized by Signatory to Receive PHI** | | | | |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **4 - Authorization Expiration Event or Date** | | | | |  |
| Unless otherwise revoked by the patient, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. If the release of PHI is ongoing, enter N/A in both fields. | | | | |  |
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| Expiration Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| **5 – Medical Records to be Released - General** | | | | |  |
| I authorize the following medical records to be released: | | | | |  |
| q Medical Records | q Dental Records | | | q Other Non-Specific |  |
| If Other Non-Specific, provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| **6 – Medical Records to be Released – Specific** | | | | |  |
| I authorize the following medical records to be released: | | | | |  |
| q Communicable Diseases | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Reproductive Health | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q HIV Test Results | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Mental Health | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Substance Use Disorder | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Other | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| If "Other", provide details: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |
| **Requests for psychotherapy notes require a separate release of medical records form and may not be combined with any other request.** | | | | |  |
|  |
| q Psychotherapy Notes | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| Release of Medical Records Form | | | | | |
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| **AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION** | | | | | |
| Please complete **all sections** of this release of medical records form. If any sections  are left blank, this form will be invalid. Use N/A if not applicable. | | | | | |
|  |
| **7 - Purpose of the Release or Use of Information** | | | | | |  |
| q Health Care q Research | | q Marketing | q Sale q Legal | | |  |
| q Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Note: The sale of PHI authorized by this release of medical records form will result in remuneration to the party specified in Part 2. | | | | | |  |
| **8 - Authorization Information** | | | | | |  |
| I understand the following: | |  |  | | |  |
| 1. I authorize the use or disclosure of the medical records as described above for the purpose indicated until such event or time as specified in Part 4. | | | | | |  |
|  |
| 2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Part 2. The revocation will prevent further release of my medical records from the date of receipt. | | | | | |  |
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|  |
| 3. I am signing this authorization voluntarily and understand my entitlement to health care or health plan benefits will not be affected if I do not sign this release of medical records form. | | | | | |  |
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| 4. If the party specified in Part 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the released medical records may no longer be protected by federal and state privacy regulations. | | | | | |  |
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|  |
| 5. I have a right to receive a copy of this authorization. | | | | | |  |
| 6 (if applicable). My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization. | | | | | |  |
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| **9 - Additional Conditions that Apply to this Release of Medical Records Form** | | | | | |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| **10 - Signature by or on Behalf of Individual** | | | | | |  |
| Name of Individual (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |
| Name of person signing form if not individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Authority to sign on behalf of individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Name of translator (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |
| Signature of translator (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  |