River Valley HEALTH

For Office Use Only
Chart #:

Authorization to Release and/or Obtain Health Records

Patient Information:

Name: _____ Date of Birth: _____

Phone Number: _____ Address: _____

City: _____ State: _____ Zip: _____

Record Requested to be Sent From:

Facility Name: _____ Fax Number: _____

Phone Number: _____ Address: _____

City: _____ State: _____ Zip: _____

Record to be Sent To:

Facility Name: _____ Fax Number: _____

Phone Number: _____ Address: _____

City: _____ State: _____ Zip: _____

Records Requested*: **Record Request Dates:** ***From*:** _____ ***To*:** _____

- ☐ Medical Records
- ☐ Behavioral Health Records
- ☐ Substance Use Disorder Treatment Records
- ☐ Other (Please Specify) _____

***** I understand and agree that the records I authorize for release may include information that could be considered information about family planning services and communicable disease, which may include, but is not limited to: hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). I understand that my substance use disorder treatment records, if any, are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise required for by the regulations, by other applicable law, or by an Order of a court. I also understand that by authorizing release of Medical Records, there may be some limited information included about substance use and/or behavioral health diagnosis and treatment in the medical record.

Purpose:

- ☐ Personal Use
- ☐ Legal
- ☐ Disability
- ☐ Coordination of Care
- ☐ Transfer of Care
- ☐ Other _____

Patient Signature:

I hereby certify that I am: 1. At least 16 years of age if requesting Behavioral Health and/or Substance Use Disorder Records, or at least 18 years of age if requesting Medical records, or 2. The parent, legal guardian, or legal custodian of a service recipient who is under 16 years of age if requesting Behavioral Health and/or Substance Use Disorder Records, or at least 18 years of age if requesting Medical Records, or 3. The conservator or guardian for the service recipient, or 4. The guardian-ad-litem of the service recipient for the purposes of the litigation in which the guardian-ad-litem serves, or 5. The attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient, or 6. The executor, administrator, or personal representative on behalf of a deceased service recipient. I understand this authorization is valid for 12 months from the date of signature and that I may cancel this request by written notification signed by me, but that it will not affect any information released prior to written notification of cancellation.

Printed Name: _____ Authorized Signature: _____ Date: _____

Relationship to Patient:

- ☐ Self
- ☐ Other: _____