

## Authorization to Release Protected Health Information

**Patient Information:**

(One Patient Per Form)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Treatment Facility/Physician: \_\_\_\_\_

Treatment Dates: \_\_\_\_\_

☐ Check here if Information will be mutually exchanged (allows both the sender and recipient(s) to share the information below with each other) this is for Behavioral Health information only.

**Information Requested (select all that apply):**

<p><b>Medical Records</b></p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Facility Summary (includes all items in <b>bold</b>)  <input type="checkbox"/> <b>Discharge Summary</b>  <input type="checkbox"/> <b>History &amp; Physical</b>  <input type="checkbox"/> <b>Consultation Reports</b>  <input type="checkbox"/> <b>Office/Progress Notes</b>  <input type="checkbox"/> <b>Emergency Record</b>  <input type="checkbox"/> <b>Operative Reports</b>  <input type="checkbox"/> <b>Laboratory Reports</b>  <input type="checkbox"/> <b>Pathology Reports</b>  <input type="checkbox"/> <b>Radiology Reports</b>  <input type="checkbox"/> <b>Immunizations</b> </div> <div style="width: 50%;"> <input type="checkbox"/> Sleep Study Reports  <input type="checkbox"/> Entire Medical Record  <input type="checkbox"/> Other: _____    <p><b>Behavioral Health</b></p> <input type="checkbox"/> Treatment Records (Treatment Plans &amp; Notes, Assessment, Psych Eval, Labs, Medications)  <input type="checkbox"/> Psychological Test Results  <input type="checkbox"/> Legal Status/Court Records         </div> </div>	<p><b>Imaging (requires CD format)</b></p> <input type="checkbox"/> Radiology Images (X-Ray/CT/MRI/US) <input type="checkbox"/> Cardiology Images (Echo/Cath Lab) <input type="checkbox"/> Neurology Images (EEGs) <input type="checkbox"/> Fetal Ultrasound Images <input type="checkbox"/> Other Imaging: _____	<p><b>Billing</b></p> <input type="checkbox"/> Itemized Bill(s) <input type="checkbox"/> UB04 Form <input type="checkbox"/> CMS 1500 Form <input type="checkbox"/> Other Billing: _____
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**Release the Requested Information to:**

\_\_\_\_\_  
 (Name of Facility, Person, Company)
 (Street Address or PO Box, City, State, ZIP Code)

\_\_\_\_\_  
 (Phone Number)
 (Fax Number)
(Email Address)

**Purpose of Release:**

☐ Continuation of Care
 ☐ Personal (at my request)
 ☐ Legal/Investigation
 ☐ Insurance
 ☐ Other: \_\_\_\_\_

**Requested Format/Delivery Method: (Fees may apply)**

<p><b>By Mail:</b></p> <input type="checkbox"/> Paper Copy <input type="checkbox"/> CD	<p><b>Electronically:</b></p> <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Patient Portal	<p><b>Other:</b></p> <input type="checkbox"/> In Person Pick-up at: _____ <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> Paper           <input type="checkbox"/> CD         </div>
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**Your Rights Regarding This Authorization:** I may revoke this authorization at any time by providing written notice to the health information department. Any revocation will apply only to information that has not yet been released. I have the right to inspect and receive a copy of this authorization. Refusing to sign this form will not affect my ability to receive treatment, payment, health plan enrollment, or eligibility for benefits. I understand that information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by federal and state privacy laws. This is a full release, including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.

**Expiration:** This authorization expires one year from the date of my signature unless otherwise written here: \_\_\_\_\_

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Note:** If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign; however, supporting documentation may be required. **Minor Authorization:** If a minor consented to treatment by a licensed physician for pregnancy, sexually transmitted diseases, outpatient behavioral or mental health care, or outpatient treatment for controlled substances or alcohol without parental consent, the minor may sign this authorization. If the minor is receiving substance use disorder treatment with parental or guardian consent, both the minor and the parent or guardian may sign this authorization.

Signature of Minor: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

