# Heritage Health
Healthcare from the Heart

# AUTHORIZATION TO RELEASE **MEDICAL RECORDS**

*(AUTHORIZATION TO RECEIVE AND/OR RELEASE PROTECTED HEALTH INFORMATION)*

Name: ______________________________________________
(Last) (First) (M.I.)

DOB: ____________________ Phone: ____________________ ☐ Home ☐ Cell

Address: ______________________________________________
(Street) (City) (State) (Zip)

I, the patient ____________________ authorize the release of health information about me as described below:

**1. INFORMATION TO BE RELEASED FROM:**

Organization, Physician, or Provider: ______________________________________________

Address: ______________________________________________
(Street or PO Box) (City) (State) (Zip)

Phone: ____________________ Fax: ____________________ Email: ____________________

**2. INFORMATION TO BE RELEASED TO:**

Organization or Person: ______________________________________________

Address: ______________________________________________
(Street or PO Box) (City) (State) (Zip)

Phone: ____________________ Fax: ____________________ Email: ____________________

**3. WHAT INFORMATION TO BE RELEASED:**

☐ Information from the most 2 recent years of visits since last seen

☐ Information from date **(YOU MUST INDICATE DATES)**: from: ____________________ to: ____________________

☐ Specific information (please specify): ______________________________________________

☐ I authorize **VERBAL COMMUNICATION** about my medical history and care to the person listed in section 2.

This record is requested for the following reason **(REQUIRED)**:

☐ Transfer of Care to (Name of Provider): ______________________________________________

☐ Going to Specialist ☐ Insurance Purposes ☐ Personal Interest ☐ Legal Purposes

☐ Other (please specify):

**METHOD TO RELEASE RECORDS:** ☐ Fax ☐ Mail Paper ☐ Mail CD ☐ Email

*CONT.* →

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*CONT.*

Federal regulations require a description of how much and what kind of the following information is to be disclosed. The following items must be individually initialed to be **EXCLUDED** in the use or disclosure of other health information: Federal law prohibits the re-disclosure of such information.

_______*HIV/AIDS related health information and/or records

_______*Birth Control/Pregnancy information and/or records

_______*Mental Health information and/or records

_______Other_________________________________________

_______*Sexually Transmitted Disease information and/or records

_______*Drug/Alcohol diagnosis, treatment and/or referral information

_______*Genetic testing information and/or records

_______*Restricted protected health information

**Agreement must be terminated in writing or documented oral agreement to restrict disclosure.**

_______*Psychotherapy Notes (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

» I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

» I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used disclosed under this authorization. I also understand there may be charges for these copies.

» I understand that I may revoke this authorization at any time to the extent that action has been taking in reliance thereon. To revoke this authorization, I must submit my request in writing to the medical records department.

4. Signature: ______________________________________________ Date: ________________
*(Patient or Member, Guardian*, or Authorized Representative*)*
*[*Documentation may be required to prove authority to sign on behalf of the patient.]*

5. Minor's Signature: ______________________________________________ Date: ________________
*(Signature of minor ages 13-17 is required for certain information.)*

6. Authorization expires one year from date signed or on date/event indicated here: ________________________

Date Received: ____________________ Initial________ Date Released: ____________________ Initial________