

Authorization to Release/Obtain Confidential Medical/Dental Records



1. Patient Information:

Patient's **legal** name: _____

Previous names: _____

Date of birth: _____ SS#: _____ - _____ - _____

2. Information may be released **FROM**:

Name of provider or organization **RELEASING** information: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

3. Information may be released **TO**:

Name of person or organization **RECEIVING** information: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

OR

Email address: _____

4. What kind of information do you want released? (copy fees may apply)

All records from last 2 years of **MEDICAL** visits All records from last 2 years of **DENTAL** visits

All records from date ____ / ____ / ____ to ____ / ____ / ____

Specific information (explain): _____

Other (explain): _____

5. I specifically consent to the release of information that may be in my record relating to sexually transmitted diseases, mental health/psychiatric disorders, drugs and alcohol history and/or HIV/AIDS information unless I say otherwise below. I do **NOT** want the following information released:

6. Why are you asking for this information? (check **ONE** box)

Doctor Lawyer Personal Insurance Other: _____

7. I understand that:

- Once information is released, it could be re-released by the person receiving it (if they are not a hospital, clinic, doctor, or health insurance company) and may no longer be protected under health information privacy laws.
- I have the right to cancel this authorization at any time by writing to CHC Medical Records. If I cancel my authorization, it will not affect any action already taken by CHC based on this authorization.
- CHC cannot condition treatment, payment, enrollment, or eligibility on whether I sign this authorization.

8. This authorization expires _____ . If no date or event is specified, it expires 90 days from the date it is signed.

Signature: _____ Date: _____

Patient, parent, guardian, or authorized representative (documentation of authority to sign on behalf of patient may be required)

If not patient, relationship to patient: _____ Printed name: _____

Signature: _____ Date: _____

Minor Signature (**REQUIRED** if patient is 13-17 years old)