Authorization to Release/Obtain Confidential Medical/Dental Records

COMMUNITY HEALTH Care
MEDICAL • DENTAL • PHARMACY

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)