AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

CHCC OUTPATIENT THERAPY

I, _____ (the "undersigned"), authorize the following covered entity:
(Requestor's Last/First Name)
Provider/Facility Name: _____
Address: _____
to release information from the record(s) of: _____
(Patient/Resident's Last/First Name)
DOB: _____ covering the period(s): from _____to _____

INFORMATION TO BE RELEASED

☐ All Medical Records (includes all records below) or ☐ Selected Records as listed below

☐ Discharge Summary (ies)	☐EKG's
☐ Operative/Procedure Report(s)	☐ Diagnostic Imaging Report(s)
☐ History and Physical	☐Laboratory Results/Pathology Reports
☐ Progress Notes	☐Consultation Report(s)
☐ Physical Therapy Notes	☐ Nurse's Notes
☐ All Billing Information	☐ Other: _____

INFORMATION TO BE RELEASED TO

Name: _____ FOR (if applicable) _____
Address: _____
Phone: _____ Email: _____

PURPOSE OF DISCLOSURE: _____

SPECIFIC AUTHORIZATION: I understand that this consent is to include disclosure of: (*requires your Initial*)

☐ HIV/AIDS related health information and/or records ☐Genetic testing information and/or records
☐ Mental health information and/or records ☐ Psychiatric information and/or records
☐ Alcohol/drug diagnosis, treatment or referral information and/or record.
Describe: _____

I UNDERSTAND THAT: the information described above may be re-disclosed and no longer protected by these federal privacy regulations if the person or entity receiving the information is not a health care provider or health plan covered by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under federal confidentiality requirements. I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire ninety (90) days from the date of signing or until (date/event) _____

UNDER PENALTIES OF PERJURY, I, the undersigned, hereby certify foregoing is true, accurate and correct.

SIGNATURE: _____ NAME: _____

Relationship to patient (if not patient): _____ Date: _____

If signature is provided by legal representative, please attach documentation of legal status.