NHRMC Physician Group

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Section A:* Must be completed for all authorizations

PATIENT IDENTIFICATION: _____
First Middle Maiden/Former Last

Date of Birth _____ Social Security # XXX-XX-_____ Phone # _____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

☐ ALL RECORDS AND DETAILS ☐ APPT INFORMATION ☐ BILLING INFORMATION ☐ CONSULTS
☐ HISTORY & PHYSICAL ☐ HIV/AIDS _____ (INITIALS REQUIRED) ☐ IMMUNIZATIONS ☐ LAB/PATHOLOGY REPORTS
☐ MEDICATION RECORDS ☐ OFFICE/CLINIC NOTES ☐OPERATIVE REPORT ☐ PHYSICIAN ORDERS
☐ PRENATAL RECORDS ☐ PROGRESS NOTES ☐ PSYCHIATRIC REPORTS _____ (INITIALS REQUIRED)
☐ RADIOLOGY REPORT ☐ SUBSTANCE ABUSE _____ (INITIALS REQUIRED) ☐ VIDEO / DIGITAL IMAGES

PURPOSE OF RELEASE: ☐ On-going communication ☐ Copy of record ☐ Legal or Insurance Review ☐ Authorized Representatives Request ☐ Personal Use ☐Other: _____

AUTHORIZATION:* I authorize and request _____ to release medical information
NAME OF PRACTICE
to _____ concerning my treatment to cover the period from _____ to _____.

Section B: Must be completed only if a health plan or a health care provider has requested this authorization

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No_____

Section C:* Must be completed for all authorizations

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials*** _____
I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I will be given a copy of this authorization form, after signing. **Initials*** _____

Section D:* Must be completed for all authorizations

I hereby authorize the use or disclosure of my personal health information as described above. I understand that I may refuse to sign this authorization and that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
I understand that I may revoke this authorization at any time by notifying The Medical Records Department in writing and that this will automatically **expire on _____/_____/_____* (MM/DD/YY)** or 1 year from the date signed below, whichever is earlier. This hereby releases the sender from all legal responsibility or liability of the release of information described above from the records. I also understand that if I revoke my authorization it will not have any effect on any actions the practice took before it received the revocation. I understand that medical records, laboratory reports, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

Printed Name: _____
(Patient or Authorized Representative)

Date: _____ **Signature:** _____
(Patient or Authorized Representative)

Witness: _____ **Relationship (if other than patient)** _____

FOR NHRMC PHYSICIAN GROUP / CHA SYSTEM USED ONLY, NHRMC PG EMPLOYEES PLEASE COMPLETE

☐ Identification Verified ☐ Copy of authorization given to patient
☐ Date of Release: _____ **via** ☐ Mail ☐ Fax ☐ Other_____
☐Accepted - Released Information as described above ☐ Partially Accepted – Describe patient information not released: _____
_____
Employee Name and Title_____
Employee Signature: _____ Date: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

THIS FORM WILL BECOME PART OF YOUR PERMANENT MEDICAL RECORD