CHS Community Health Services
Your Partners for Better Health

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____
Last First MI Maiden or Other

_____ _____ _____
DOB SSN Telephone Number

_____ _____ _____
Address City/State Zip Code

INFORMATION RELEASED FROM:

_____
Name

_____
Address

_____
City/State/Zip

_____
Phone # FAX #

INFORMATION RELEASED TO:

_____
Name

_____
Address

_____
City/State/Zip

_____
Phone # FAX #

INFORMATION TO BE RELEASED OR INSPECTED: (Check all applicable categories.)

From _____ **to** _____ **If no dates listed, we will send only 1 year of information.**
(Date) (Date)

_____ Entire Chart/Record, including, but not limited to, all of the following:

___ Office Notes
___ Diagnostic Imaging Reports
___ Laboratory Reports
___ Emergency Room/Hospital Reports
___ Pharmacy/Prescription/Medication Listing
___ Nursing Home, Home Health, and Hospice Records
___ Copies of Reports Originating From Other Providers
___ Immunizations
___ Diagnosis/Problem List
___ Prenatal Records
___ PT, OT, and/or Speech Therapy Notes
___ Billing and Patient Account Records
___ Appointment Information
___ Dental Records
___ Other: _____

_____ HIV and Communicable Disease Testing (Confidential)

NOTE: For patients transferring medical care to another provider, you will also be required to transfer your Behavioral Health provider (if applicable). Also, if transferring your medical care to another provider all future appointments will be cancelled.

REASON FOR DISCLOSURE: □ Transfer of provider □ Transfer of OB/Gyn provider □ Other _____

This authorization will remain in effect for one (1) year or until _____ and will be effective for medical records generated up to the date of the signature. I understand that:

1. I may revoke this authorization in writing at any time by notifying the Privacy Officer at 410 Birchard Avenue, Fremont, Ohio 43420. I also understand that this authorization will cease to be effective on the date notified except to the extent that information has already been released in response to this authorization.
2. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and the disclosed information is no longer protected by the privacy regulations of the practice.
3. My treatment, payment or eligibility for benefits or enrollment in a health plan may not be conditioned on obtaining this authorization.
4. My refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.
5. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee as established by state or federal guidelines.
6. I am entitled to a copy of this authorization after I have signed it. This copy will be made available to you upon request. A FAX copy/photocopy of this authorization shall be considered as valid as the original.

_____ _____
Signature of Patient Signature of Parent/Guardian/Authorized Person

_____ _____
Date Date

Reason Patient Unable to Sign: ___Minor ___Incompetent ___Deceased

For Office Use Only: (please date and initial)

Put on Disk _____ Mailed _____ Faxed _____ Printed & Given _____ Picked Up _____ PHI Request Complete _____

Mailing Address: 410 Birchard Avenue, Fremont, OH 43420 * Phone: 419-334-3869 * Fax: 419-334-8546