## **AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION**

## For questions, please contact your Office at (919) 833-3111

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI Maiden or Other Name

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Advance Community Health Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Month Day Year

|  |
| --- |
| **Request Records From:**I hereby request my medical/dental information from:Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Release Records To:**I hereby authorize Advance Community Health to release medical/dental information as indicated below to:Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Information to be Requested/Released:**(you must enter and select from the following)Dates of Service: \_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_OR:* All of My Dates of Service

Include (Choose):* Office Visits
* Lab Reports
* Immunizations
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | I specifically authorize the release of information relating to:* Substance Abuse (including alcohol/drug abuse)
* Mental Health (including psychotherapy notes)
* STD, HIV, and HIV related information (including STD testing)
* None of the above

Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Signature of Patient/Guardian Date |

|  |
| --- |
| **Purpose of Disclosure (choose one):*** Changing Physicians
* School
* Consultation/Second Opinion
* Workers Compensation
* Continuing Care
* Insurance
* Legal
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

I am the (choose one): 1. I understand that I may revoke this authorization at any time by notifying the

* Patient providing organization in writing.
* Guardian 2. I understand that information used or disclosed by signing this authorization may be
* Authorized Person subject to re-disclosure by the recipient and no longer be protected by Federal
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ privacy regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature or Mark Date

ACH Employee Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employee Signature Date