## **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

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| **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 |

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| **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.

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Print Name Signature or Mark Date

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

Employee Signature Date