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):

- ○ Patient
- ○ Guardian
- ○ Authorized Person
- ○ Other:_____

1. I understand that I may revoke this authorization at any time by notifying the providing organization in writing.
2. I understand that information used or disclosed by signing this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

_____ _____ _____
Print Name Signature or Mark Date

ACH Employee Witness Signature

_____ _____
Employee Signature Date