The Christ Hospital™ Physicians

Site_____
Box #_____

AUTHORIZATION FOR WRITTEN RELEASE OF MEDICAL INFORMATION

PLEASE PRINT

Patient Name_____ Birth Date_____

Address_____ SS#_____

I, the undersigned, hereby authorize the release of the following information from my (or give relationship _____'s) medical record. This authorization includes release of information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric / psychological conditions, AIDS/AIDS related conditions and/or HIV testing. Review of the record is also authorized.

The following information is requested:

( ) Office/Progress Notes, medication list, and problem list
( ) Emergency Treatment(s) Hospitalization(s)
( ) X-ray films/diagnostic testing
( ) Entire medical record
( ) Limited to treatment dates and for conditions described below
( ) Immunization records and growth charts
( ) Other

REASON NEEDED

Please specify the reason for your request:

- ☐ Medical care
- ☐ Disability
- ☐ At My Request/Personal Reasons
- ☐ Legal Reasons
- ☐ Insurance
- ☐ Other _____

I understand that if the person/entity that receives the above protected health information is not a health care provider/health plan covered by federal privacy regulations, the protected health information described above may be redisclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to **(fill in entity specific name and address where revocations must be sent).**

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

Send records to:_____ **From:**_____

(Doctor) **(Doctor)**

_____ _____

(Address) **(Address)**

_____ _____

EXPIRATION

This authorization will expire in 60 days unless otherwise specified _____
(Insert date or specific event)

_____ _____

Patient/ Legal Representative* Date

*Reason Patient is unable to sign _____

*Describe scope of authority to act for patient:_____

Provide guardianship, executor of estate, power of attorney papers.

_____ _____

Witness Signature Date

( ) Internal Transfer ( ) External Transfer ( ) Originals Sent