Authorization for Release of Medical Records

Patient Name:_____ **DOB:**_____
Last First Middle

Address:_____
Street City State Zip

Telephone:_____ **Last 4 Numbers of SSN:**_____

Release Information FROM:

_____
Facility / Practice / Company

_____
Address

_____
Contact / Telephone / Other Pertinent Information

Release Information TO:

_____
Facility / Practice / Person / Company

_____
Address

_____
Contact / Telephone / Other Pertinent Information

Purpose of Release: ☐ Patient Request ☐ Insurance ☐ Disability ☐ Worker's Compensation
☐ Legal Process ☐ Other:_____

Treatment Dates For Record Release (must be completed): From:_____ **To:** _____

Check All That Apply:

☐ Entire Record *Excluding Psychotherapy Notes*
☐ Psychotherapy Records
☐ Consultation Reports
☐ Medications
☐ Office Visits & Physical Exams
☐ Drug and Alcohol Abuse Treatment
☐ Diagnostic Tests & Radiology Reports
☐ Billing & Financial Information

Format (Charges May Apply): ☐ Paper Copy ☐ Electronic Copy ☐ CD ☐ Other:_____

Delivery Method: ☐ U.S. Mail ☐ On-Site Pick-Up ☐ Email ☐ Facsimile ☐ Other: _____

I understand that:

- I can cancel this permission at any time. I must cancel in writing and notify the releasing and receiving parties listed above. Any cancellation will apply ONLY to information not yet released.
- This is a full release, including information related to, genetic information, HIV/AIDS, and other sexually transmitted diseases, **unless limited by the above selections.** (in compliance with HIPAA 42 CFR, Part 2, CFR 45, Part 164 of the Federal Register)
- Information that is disclosed under this authorization may be re-disclosed by the person to which it is given. The privacy of this information may not be protected under the Federal Privacy Rule.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.

This permission expires 90 days after the date of my signature, unless another date is written here:_____

_____ _____ _____
Print Name (Patient/Legal Guardian/POA) Signature Date

_____ _____ _____
PSYCHOTHERAPY Release Age 12-18 years Print Name **Signature** **Date**

ID Verified ☐ **By Heartland Employee:**_____ **Title:**_____

Date of Release:_____**Heartland Employee:**_____ **via:** ☐ **mail** ☐ **fax** ☐ **Other:**_____