# Medical Record Release Form

CHI St. Joseph Health

Name: _____ DOB: _____ SS: _____

Address: _____ Phone: _____

***From/To (Please circle intended direction)***

| Name: | Phone: | Fax: |
|---|---|---|
| Address: | | |

***From/To (Please circle intended direction)***

| Name: | Phone: | Fax: |
|---|---|---|
| Address: | | |

***Purpose of Disclosure:***

| ☐ Continuity of care | ☐ Insurance | ☐ Legal | ☐ Personal Use |
|---|---|---|---|
| ☐ Transfer of care | ☐ Other (please be specific) | | |

***Records to include:***

This authorization pertains to the disclosure of record types indicated below between following dates of service: From: _____To:_____ OR ☐ All records retained by this facility.

| ☐ Progress Notes | ☐ Lab Notes | ☐ Immunization Records | ☐ Operative Reports |
|---|---|---|---|
| ☐ Hospital | ☐ Imaging Records | ☐ Other: | |

I aknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____***Intials***

**Expiration**: This authorization shall expire 180 days from date of signature.
I understand that this autorization may be revoked by me at anytime except to the extent that action has been taken. I have the right to revoke this authorization at any time prior to 180 days by giving the healthcare provider written notice of revocation of this autorization. _____***Intials***

**Re-disclosure**: I understand the information disclosed by this autorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

I understand that:

- I have the right to refuse to sign this autorization
- I have the right to receive a copy of this authorization
- I have the right to inspect or copy the protected health information to be used or disclosed
- Fees/charges will comply with all laws and regulation applicable to release of information

I have read the above and authorize the disclosure of the protected health information as stated.

| _____ | _____ | _____ |
|---|---|---|
| Date | Signature of Patient/Parent/Guardian | Relationship to patient |