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