Reinhart Family Healthcare

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENTS NAME____ DATE OF BIRTH_______________

Please print name, address and phone number from whom records are being requested.

FROM:____ PHONE: ________________________

For the following reason(s): ____

Designate instructions by checking one of the following:

_______Entire medical record **including** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_______ Entire medical record **excluding** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_______ Record care from____________to____________**including** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted disease and HIV/AIDS.

_______ Record care from____________to____________**excluding** information related to the treatment of substance abuse or dependency mental health treatment and information relating to testing or treatment of sexually transmitted disease and HIV/AIDS.

_______Other as stated: ____

CONDITIONS:

- The patient agrees to authorize the above-named individuals/organizations to access his/her confidential healthcare information only for purposes listed above
- The patient has the right to a copy of the confidential healthcare information for which this authorization is being sought
- The practice may not condition treatment or payment on whether the patient signs this authorization
- The patient authorizes the information to be disclosed by fax transmission, if necessary
- The patient is voluntarily signing this authorization
- The patient reserves the right to refuse to sign this authorization
- The patient reserves the right to revoke this authorization at any time in writing
- The patient has the right to receive a copy of the signed authorization

I authorize records to be released as indicated above. I understand that this release is in effect for one year from date of signature, but I may revoke my consent at any time by providing written revocation to the facility releasing the information.

SIGNATURE:
Patient/Legal Representative: ____ Date: __________________

Reinhart Family Healthcare

Authorization to Release Information to Family and Friends

Due to federal privacy laws, we are unable to release certain personal health information without your consent. If you wish for information to be released, this form must be completed, signed and returned. In your absence, you must designate personal representative(s) for any personal health information to be released. The written authorization does not mean that we will automatically send information to these individual(s); it simply means that we will release information to them if they request. Such information includes, but is not limited to: individual identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

PATIENT NAME:_______________________________________ DOB: ___________________

Release information to the following representative(s):

Name:___________________________Relationship:_____________________Phone: ____________

Name:___________________________Relationship:_____________________Phone: ____________

Name:___________________________Relationship:_____________________Phone: ____________

Name:___________________________Relationship:_____________________Phone: ____________

REASON FOR DISCLOSURE: ____

CONDITIONS:

- The patient agrees to authorize the above-named individuals/organizations to access his/her confidential healthcare information only for purposes listed above
- The patient understands there is a potential that the information disclosed may be re-disclosed by the recipient and no longer protected by HIPAA regulations
- The practice may not condition treatment or payment on whether the patient signs this authorization
- The patient authorizes the information to be disclosed by fax transmission, if necessary
- The patient is voluntarily signing this authorization
- The patient reserves the right to refuse to sign this authorization
- The patient reserves the right to revoke this authorization at any time in writing
- The patient has the right to receive a copy of the signed authorization

I hereby authorize Reinhart Family Healthcare to provide the above-named individual(s) with <u>all</u> medical data, billing, and other information they may request. I understand that this release is in effect for two years following my death or I may revoke my consent at any time by providing written revocation to the facility releasing the information.

Signature of Patient____ Date_______________