Medical Records Release Authorization

Upon presentation of this authorization you are requested to provide the records outlined below to:

Online User: _____

To Recipient:

_____
Person/Company

_____
Address

_____
City **State** **Zip**

_____
Phone **Fax**

_____
Recipient E-Mail

From Clinic/Hospital: _____

Patient:

_____
Patient Name **Date of Birth**

_____
Patient E-Mail **Phone**

Dates of Service: Please provide dates of service _____ through _____

Records to be Released (45 CFR § 164.508(c)(1)(i)).

☐ Part 2 - Substance Use Disorder - Medication-Assisted Treatment Records

Purpose for Disclosure

☐ Patient ☐ Physician ☐ Disability ☐ Insurance ☐ Attorney ☐ Other _____

Please Indicate your acceptance by checking the following boxes:

☐ I understand that I (or patient, if requested from third-party source) may revoke this authorization (or an attached authorization) in writing at any time except to the extent that action has been taken in reliance upon this authorization. (45 CFR § 164.508(c)(2)(i))

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization (or an attached authorization), except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. (45 CFR § 164.508(c)(2)(i))

☐ I understand that my (or the patient's, if requested from third-party source) records are confidential and cannot be disclosed without written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization (or an attached authorization) may be subject to re-disclosure by the recipient and no longer protected, except as provided for by law. I understand that the specified information to be released may include, but is not limited to history, diagnosis, and/or treatment or communicable disease, including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), records related to reproductive health, and/or genetic documentation as related to Genetic Information Nondiscrimination Act (GINA). (45 CFR §164.508(c)(2)(i)).

☐ I understand that the specified information to be released may include, but is not limited to history, diagnosis, and / or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus(HIV), Acquired Immune Deficiency Syndrome(AIDS), and genetic documentation as related to Genetic Information Nondiscrimination Act(GINA). (45 CFR §164.508(c)(2)(i))

This authorization will expire One Hundred Eighty (180) days from the date of signature unless revoked by authorized party prior to that time. If a third-party request, expiration will also expire One Hundred Eighty (180) days from the date of signature unless explicitly written in an attached authorization.

Date: _____ Signature: _____