Authorization for Release of Health Information

For HPFC Staff Use Only:
Request ID # _____
Patient ID # _____
Release Date/By:_____

IMPORTANT: This is a legal document; please complete each section to ensure we are able to process your request.

Patient Name: _____ Previous Name: _____

Address: _____ Apt #:_____

City, State, Zip:_____ Date of Birth: _____ Phone: _____

Release Information From:	☐ _____ Street: _____ City: _____ State: _____ Phone: _____ Fax: _____
Release Information To:	☐ _____ Street: _____ City: _____ State: _____ Phone: _____ Fax: _____
Method of Disclosure:	☐ Mail ☐ Pick Up (*will call when ready*) ☐ Fax (*Urgent Only-limitations may apply*) ☐ File Only-No records needed at this time ☐ Phone Consult
Health Information to be Released:	Date(s): Requesting From: _____ To: _____ (*specific date or date range preferred)* *If no specific dates(s) are provided, only the most recent document(s) for items that are marked below will be sent.* All Medical Records For: ☐ Clinic Visits ☐ Attendance ☐ Diagnoses Or Specifically/Only: ☐ Clinic Visit Notes ☐ Laboratory/Pathology ☐ Radiology Report ☐ Medication List ☐ Allergies ☐ Other (*Please specify*): _____ I understand the records to be released may include information related to evaluation or treatment of behavioral or mental health, alcohol and drug abuse, and HIV/AIDS. I understand this authorization releases records for dates requested above and may include records prepared or collected by the facility prior to the date of signature on this authorization and/or may include records prepared of collected by the facility after the date of the signature on this authorization.
Reason for Release:	☐ Consult/Treatment ☐ Insurance ☐ Out of town move ☐ Workers Comp ☐ Disability ☐ Legal ☐ Personal ☐ Other: _____
Authorization Expiration:	This authorization is valid for one year from the date signed unless otherwise noted below. Specified here: _____
Revocation:	I understand I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the HPFC. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Authorization:	I understand authorizing the release of this information is voluntary. I understand I may inspect or be provided a copy of the information to be used or disclosed, as provided in CRF 164.524. I understand any release of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I may contact Health Partners Free Clinic. I understand the facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand this is a legal document and by signing, I agree that I understand and accept the terms on this form: _____ _____ / _____ / _____ Signature of Patient or Authorized Representative — Date of Signature _____ _____ Printed Name of Authorized Representative — Relationship to Patient or Description of Legal Authority (*documentation of legal authority required, please submit*)

Submit completed form to: Health Partners Free Clinic, 1300 North County Road 25A, Troy, OH 45373
937-332-0894 Phone
937-339-7084 Fax