Release of Medical Records and

Authorization for Use or Disclosure of protected Health Information

Please complete the following information

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____ Date of Birth: _____/_____/_____

I hereby authorize: _____ of (Address) _____

_____ to disclose my records to _____

Of (Address) _____

All records Lab/pathology X-ray/radiology Billing Cardiac/EKG

Other: _____

The purpose for disclosing the above information is indicated by circling one below:

Continuing care Relocation Insurance Legal Other: _____

I understand that I have no obligation to disclose information from my record and that I may revoke this authorization by submitting a request in writing along with a copy of this form to the medical records department of this office. I understand that any action already taken prior to revoking my authorization cannot be reversed and my revocation will not affect those actions.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the information may be re-disclosed and no longer be protected by federal privacy regulations.

Please note, if these records contain any information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you hereby authorize disclosure of this information

This authorization shall expire 12 months from the date at which it was filled out and signed.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated.

_____ _____ _____/_____/_____

Print patients full name *Signature of Patient/Legal guardian* *Date*

Note: EOPCC **does not** accept faxed or hand delivered medical records. All records must be sent from requested physician's office to be accepted for consideration.

This authorization will not be valid unless completely filled out in its entirety.