Patient Authorization for Release of Health Records

I authorize the ADAMS Compassionate Healthcare Network Clinic to disclose information from the health records of:

_____
(Name of Patient)

1. MRN #: _____ Date of Birth: _____
2. **The information is to be disclosed to**: _____

   Address: _____

   City, State, Zip: _____

   Contact Person: _____

   Phone/Fax: _____

3. I authorize this information to be disclosed in the following ways:
   ☐ Written/Photocopy/Paper ☐ Verbal ☐ Fax

4. **Purpose of the disclosure**: _____

5. **Specific reports to be disclosed**:
   ☐ Progress Notes ☐ Laboratory Reports ☐ Operative Reports
   ☐ Discharge Summary ☐ Radiology Reports ☐ Consultation Reports
   ☐ X-ray films or other images ☐ Photographs/Videotapes ☐ Records from other facilities
   ☐ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
   ☐ Other (Specify):_____

6. I give specific authorization to disclose the following information:
   ☐ HIV test results ☐ Documentation of AIDS diagnosis
   ☐ Drug and alcohol abuse treatment records ☐ Psychiatric/Mental Health treatment records

7. I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the ADAMS Compassionate Healthcare Network Clinic in writing.
   My treatment will not be based on the completion of this authorization form. If the information released by this authorization is to a person or organization that is not a healthcare provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.
   Unless revoked earlier, this authorization expires in one year. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient Representative Relationship to Patient