PHONE: 678.878.5704 - FAX: 770.232.1449

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information	Name: _____ Date of Birth: _____
Clinic/Hospital/Health Care Provider: (Who has the information you want released?)	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____
Receiving Clinic: (Who will the information be sent to?)	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____
Information to be Released: (What do you want sent or released? Check the appropriate box.)	**Medical Dates of Service**: _____ ☐ Progress notes/clinic notes ☐ Diagnostic Test Reports ☐ Radiology Reports ☐ Emergency Record(s) ☐ Obstetrics Records ☐ Operative Report ☐ Lab Reports ☐ History & Physical Exam ☐ Discharge Summary ☐ Consultations ☐ Entire Record ☐ Other records/specify record types: _____ **C&S / Mental Health & Chemical Health**: **Dates of Service**: _____ ☐ Diagnostic Assessment ☐ Treatment Plan ☐ Testing ☐ Discharge Summary ☐ Medication Management ☐ Social Work Services ☐ Verbal Communication ☐ Consultations ☐ Entire Record ☐ Other, specify: _____ **Dental**: **Dates of Service**: _____ ☐ X-Rays ☐ Office Notes ☐ Other records, specify record types: _____
Release Instructions: (How and When do you want the information?)	**Release Method / Format Requested**: (check one) ☐ Paper/Mail ☐ CD ☐ Fax (patient care only) ☐ Verbal Disclosure ☐ Paper/Patient Pickup (ID may be requested at the time of pickup) ☐ Two-Way Exchange of Information
Purpose of Release: (Why is it needed?)	☐ Continuing Care/Treatment Planning ☐ Transfer of Care ☐ Personal Use or Review * ☐ Litigation/legal * determination * Other *: _____ Fees may be charged in accordance with Federal Rule 45 C.F.R. §164.524 and/or State Statutes
Acknowledgments:	I understand this release may include, but is not limited to, that which involves treatment or testing for alcohol/drug abuse, sickle cell anemia, sexually transmitted diseases, including HIV/AIDS, or mental health issues, that were maintained while a patient at your facility on any date, as well as any correspondences. This authorization may include records prior to and after the date of signature, unless noted otherwise.

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____

☐ This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Oscar Medical Center Notice of Privacy Practice describes how to cancel (revoke) this authorization.

☐ The Oscar Medical Center will not restrict my treatment if I choose not to sign this authorization.

☐ The Oscar Medical Center cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Oscar Medical Center from any and all liability resulting from a redisclosure by the recipient.

☐ Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

_____ _____ _____

Patient/Legal Guardian Signature Date Relationship to Patient/Authority to act on behalf of patient

Patient/Legal Guardian's Printed Name: _____

Revision 2/04/2015