Patient's Full Name: ______________________ Date of Birth: ______________

Social Security Number: ______________________ Medical Record No: ______________

RELEASE OF GENERAL HEALTH RECORDS

I AUTHORIZE PRESBYTERIAN HEALTHCARE SERVICES ("PRESBYTERIAN") TO USE OR RELEASE (DISCLOSE) THE FOLLOWING HEALTH RECORDS OF THE ABOVE NAMED PATIENT ("PATIENT").

☐ Dictated Reports ☐ Test Results ☐ Billing Records ☐ All Health Records
☐ Other (Please specify) ______________________

From (indicate facility): ______________________

For date(s) of service from: to ______________________

To (Name): ______________________

Address: ______________________ City: ______________________

State: _____ Zipcode: __________ Telephone Number: __________ Facsimile (FAX) Number: __________

Records released for the following purpose(s): ☐ Pick Up ☐ Mail Out
☐ At the request of the Individual
☐ For Marketing (specify campaign): ______________________
☐ If checked, Presbyterian will receive direct or indirect payment from a third party as a result of this activity.

☐ Other (Describe each purpose of the requested use or disclosure)

____

IN ADDITION TO RELEASE OF THE GENERAL HEALTH RECORDS INDICATED ABOVE, BY INITIALING BELOW I ALSO AUTHORIZE THE RELEASE OF HEALTH RECORDS PERTAINING TO THE FOLLOWING CONDITIONS.

(Initial ONLY those records to be released):

_______ Health Records Related to Drug / Alcohol / Substance Abuse

_______ Health Records Related to Sexually Transmitted Diseases

_______ Health Records Related to Human Immune Deficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS)

_______ Health Records Related to Emotional / Mental Health / Developmental Disabilities / Psychiatric Conditions **(Excludes Psychotherapy Notes. This authorization does not authorize release of Psychotherapy Notes. To release Psychotherapy Notes, a separate authorization is required.)**

EXPIRATION: I understand that I may cancel this authorization at any time by sending Presbyterian my notice of cancellation in writing. I understand that Presbyterian may have already used or released records according to this authorization prior to receiving my notice of cancellation. I understand that if this authorization is cancelled, an insurer may still have the legal right to contest a claim or the insurance policy. This right only applies if this authorization is requested as a condition of obtaining insurance coverage. **UNLESS CANCELLED, THIS AUTHORIZATION EXPIRES (either Event OR Date is required):**

☐ In 6 months ☐ When Other Event occurs (specify): ______________________
OR on Date: ______________________

I UNDERSTAND THAT THIS AUTHORIZATION TO RELEASE HEALTH RECORDS IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF PATIENT RECEIVING TREATMENT OR PAYMENT FOR SERVICES, EXCEPT AS PERMITTED BY LAW. I have read and understand this authorization form including statements that appear on the reverse side of this page. I am the Patient or I am legally authorized as the Patient's representative to execute this authorization and accept these terms.

______________________ ______________ ______________
Patient or Authorized Representative/Relationship to Patient Date Time
(Relationship to Patient required if signed by Representative)

____
Print Name if Other than Patient

AUTHORIZATION FOR USE AND RELEASE OF HEALTH RECORDS

2227 (Rev. 8/06) White Copy - Chart Canary Copy - Patient