Authorization for Release of Health Information

Patient information	Name		Date of birth
	Address		Phone number
	City	State	Zip Code
Release information from	Specific Carris Health clinic / hospital or provider		
	Address		Phone number
	City	State	Zip Code
Release information to	Name of person, business, specific clinic / hospital or healthcare provider		
	Address		Phone number
	City	State	Zip Code
Information to be released Only the information check marked will be released	**Date(s) of service: from _____ to _____** **Note: If dates are not specified, only the most recent visit/encounter will be released.** ☐ History and Physical ☐ Pathology reports ☐ Radiology reports ☐ Discharge summary ☐ Consult reports ☐ *Radiology films ☐ Emergency room notes ☐ Laboratory reports ☐ All records (*not included) ☐ Progress notes ☐ Operative/Procedure notes ☐ Assessment / Evaluation ☐ Other (specify): _____		
Special Disclosure	☐ Substance use or disorder Dates of service: from _____ to _____ Concerning: _____ (Specific diagnosis or treatment – do not list ICD-10 codes) *Per Federal Rule 42 CFR Part 2, this section must be completed to release substance use disorder records.* ☐ Psychotherapy notes _____		
Reason for release	☐ Continuation or Transfer of Care (to another provider) ☐ Personal Use ☐ Attorney ☐ Insurance ☐ Other (specify): _____		
Authorization	Patient / Guardian signature		Date
	Relationship to patient		Reason patient is unable to sign
Revocation	This authorization will expire one year from the date of signature unless I indicate a different date or event here: _____. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it or upon final disposition of the conditional release for which authorization was given. I may revoke this authorization at any time by notifying, in writing, the provider / facilities listed in the FROM section. I understand that such revocation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.		

ACMC will not refuse treatment to any patient that refuses to sign an authorization for release of Protected Health Information. Once released, the information will no longer be covered under the Federal Privacy Laws. Information not originated by ACMC will not be released to another facility unless specifically requested.