## REQUEST FOR RELEASE OF MEDICAL INFORMATION

**Please Print.** *Make sure all information is complete to prevent a delay in release of information.*

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Name** (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This will authorize: To release to:**

Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider/Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1.** **Date(s) of Treatment**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Information to be Disclosed:**

 Lab and X-ray report  Emergency Room Report  Discharge Summary

 Operative Report  Progress Notes  History and Physical Examination

 X-ray Films  Consultation Report  Medical Records from last 2 years

 After Care Plan  Complete Record  Financial Record

 Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expiration date or event:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.** **Purpose for which information is to be used:**

 Treatment  Insurance  Personal  Follow-up  Legal Proceedings Other(specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I am moving and my new address is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Special authorization required if disclosure applies to treatment for any of the following condition(s):**

**Please initial:** \_\_\_\_ Drug, Alcohol Abuse/Treatment \_\_\_\_ Alcoholism or Alcohol Abuse

\_\_\_\_ HIV/AIDS Virus \_\_\_\_ Mental Health Records

This form must be dated within **90 days** of receipt. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Requests to revoke this authorization must be made in writing and submitted to Tri Valley Health System. Authorization is valid for **180 days**.

I hereby release Tri Valley Health System from all legal liability that might arise from the inadvertent release of sensitive information. **Any further disclosure of my records other than what is outlined above is prohibited without my specific written authorization, or as otherwise permitted by such regulations**. I consider a photocopy of this authorization to be as valid as the original.

I understand that I may inspect the information to be disclosed

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by this rule. Tri Valley Health System is not legally liable for re-disclosure by the recipient.

Authorization must be signed by the patient, legal guardian of the patient, or other authorized representative. If the patient is unable to give authorization, or physically unable to sign, state reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or person authorized to sign for patient/relationship Date/Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness to signature only Date/Time

**OFFICE USE ONLY** To be sent Sent on Date: \_\_\_\_\_\_\_\_\_\_\_\_

Copies by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_ To be picked up Picked up on Date: \_\_\_\_\_\_

By: \_\_\_\_\_\_\_\_\_\_\_\_ Released by: \_\_\_\_\_\_\_\_\_\_\_\_