AUTHORIZATION FOR RELEASE OF INFORMATION

(for record release to Arnot Medical Services)

ArnotHealth
Arnot Medical Services

I hearby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health or health care provider, the released information may no longer be protected by federal privacy regulations

Patient Name: **Patient Address:**	**Date of Birth:** **Social Security Number:** **Patient Phone Number:**
Persons/organizations PROVIDING the information: Office/Hospital: _____ Attn: Medical Records Department Address: _____ _____ Phone:_____ Fax:_____	**Persons/organizations RECEIVING the information:** Office/Hospital: _____ Arnot Medical Services Address: _____ _____ Phone:_____ Fax:_____

Specific description of information to be released: (Please initial next to requested information)
Special authorization form is required for drug, alcohol, HIV and psychiatric information

_____ All office notes (progress notes, lab reports, x-ray reports, EKG's, history and physical)

OR

_____ Consultation notes only
_____ Operative notes only
_____ Progress notes only
_____ Other - please list:

_____ Laboratory reports only
_____ Radiology reports only
_____ EKG/cardiology testing reports only

Dates of information: from (date)_____ **to (date)** _____
Type of access requested: Inspection only _____ Copies___ XXX_____

1. What is the purpose of the disclosure?

2. I understand this authorization will expire on ____/_____/_____ or upon compliance with the request for information, whichever occurs first.
3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.
4. I understand that my health care and the payments for my care will not be affected if I do not sign this form.

SIGNATURE:_____ **DATE:** _____

Relationship if not patient:_____

Witness:_____ Date: _____

To be completed by AMS staff or copy service:
DATE COMPLETED:_____ INITIALS:_____