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:	**Date of Birth:**
Patient Address:	**Patient Phone Number:**

Persons/organizations PROVIDING the information:	**Persons/organizations RECEIVING the information:**
Office/Hospital: _____	Office/Hospital: _____
Attn: Medical Records Department	Arnot Medical Services
Address: _____	Address: _____
_____	_____
Phone:_____ Fax:_____	Phone:_____ Fax:_____

Specific description of information to be released: (Please initial next to requested 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_____

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. **Initials:**

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. **Initials:**

4. I understand that my health care and the payments for my care will not be affected if I do not sign this form. **Initials:**

Drug, Alcohol, HIV and Psychiatric Exclusion
Initial here ONLY if you consent to the release of drug, alcohol, HIV and/or psychiatric information.
***This form is not valid for records pertaining to the Behavorial Science Unit, STARS Program and New Dawn Program.
Please contact facility where treatment occurred. **Initials:**

SIGNATURE:_____ **DATE:**_____

Relationship if not patient:_____

AMS Witness/Notary Public:_____ DATE:_____

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