AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

DISKS/CD-ROMS NOT ACCEPTED

Patient Name: _______________________________________ Date of Birth: _____/_____/______ Phone: _________________________

Address: ____ City: _________________________ State: ______ Zip Code: ___________

Healthcare Provider to ***Release*** Information:

Name		
Mailing Address		
City	State	Zip
Phone	Fax	

Healthcare Provider to ***Receive*** Information:

Name		
Mailing Address		
City	State	Zip
Phone	Fax	

PURPOSE OF THE DISCLOSURE _____ Transfer of Care _____ Coordination of Care _____ Other ______________________________

DATES REQUESTED _____ **ALL** Dates of Service **OR** Date Range: From ______________________ To _______________________

INFORMATION REQUESTED (**Must initial each item requested**): **WE CAN NOT ACCEPT DISK/CD-ROMS**

_____ Initial here to include **ALL** types of records indicated below **OR** initial the specific records requested

_____ Chart Notes
_____ Lab Results
_____ Radiology and Imaging Reports
_____ EKG Reports
_____ Specialist Consults
_____ Hospital Records
_____ Physical Therapy Notes
_____ Other ____
_____ Immunization Records
_____ Billing Statements

SPECIFIC CONSENT (**By initialing the space(s) below, I am specifically authorizing the release of the specified confidential information**):

_____ Records regarding mental illness or developmental disability*
_____ Medical Records relating to alcohol and/or drug abuse
_____ HIV Test Results
_____ Genetic Testing information and results
_____ Communicable Disease
_____ Venereal Disease
_____ Child Abuse and Neglect
_____ Sexual Assault

EFFECTIVE DATE OF AUTHORIZATION

_____ Until the purpose is fulfilled

_____ Other ____

I understand that I may revoke this Authorization in writing at any time by notifying the Medical Records Department. I understand that once my health information is disclosed to the recipient, GCH cannot guarantee that the recipient will not re-disclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be affected.

I have read and understood this authorization and had a chance to ask questions about the disclosure of the health information. I authorize GCH to release my health information in the manner described above.

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Signature of Patient or Personal Authorized by Law **Date**

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***Name and Signature of Witness** *(required for release of information about mental illness or Developmental disability)* **Date**

Staff Initials_________