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Medical Release of Information Authorization

****Fill out form in its entirety****

I authorize the use/disclosure of health information, as outlined below, for:

Patient Name: _____ Date of Birth: _____ Last 4 of SSN: _____

The information is to be released from:

The information is to be provided to:

<input type="checkbox"/> GPW Health Center <input type="checkbox"/> Organization/Individual:	<input type="checkbox"/> GPW Health Center <input type="checkbox"/> Organization/Individual:
Address:	Address:
City/State:	City/State:
Fax#:	Fax#:

*** Please note: All of the above information must be filled correctly for records to be sent in a timely manner.**

Dates of Service: From: ___/___/___ To: ___/___/___ or ___ ALL

Check the information needed:

- Office Visit Notes Lab Reports OB/GYN EKG/Cardiology Reports
 Radiology Reports Immunization Records History & Physical Pathology Reports
 Radiology Images Referral Consultation Notes Billing Statements Other (Specify) _____

I authorize the information listed below to be used, disclosed and/or received:

- Developmental disabilities information AIDS, HIV, ARC

Check the reason or need for disclosure:

- Further Medical Care Attorney Personal Use /Request of Individual School
 Insurance/Benefits Disability Determination Other (Specify) _____

The information may be transmitted via: (**must initial each** by each approved method)

- Fax Electronically (**required** to complete duty to warn) Hard Copy

I understand that:

- If the person or entity that receives the health information is not a health care provider or health plan covered by federal privacy regulations, the health information above may be subject to redisclosure and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may revoke this authorization in writing at any time by notifying the Privacy Official except to the extent that action has been taking in reliance on this authorization.
- **Unless revoked, this authorization will expire 6 months from the date signed or as specified: _____**
- I may inspect or copy any information used/disclosed under this authorization. I have received a copy of this authorization.

I further acknowledge that the information to be released has been explained to me and certify that this consent is given on my own free will.

Consent to release records was provided verbally over the phone to GPW Health Center

Signature of Patient/ Legally Designated/ Personal Representative

Date

Print Name of Legally Designated or Personal Representative

