GPW Health Center

Dedicated to Your Health!

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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:**
☐ **GPW Health Center** ☐ **Organization/Individual:**	☐ **GPW Health Center** ☐ **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 ___ School ____ Personal Use /Request of Individual
____Insurance/Benefits ___Disability Determination ____Other (*Specify*) _____

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

_______ Fax _______ Verbal ______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.

______________________________________ ____________________

Signature of Patient or Legally Designated or Personal Representative **Date**

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Print Name of Legally Designated or Personal Representative

Revised 02/24/19