COMMUNITY CARE NETWORK
Community Healthcare System®

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name			Phone Number	
Address			Date of Birth	
City			Social Security Number	
State, Zip Code				(last 4 digits only)

I authorize: _____

(Specify where you are requesting information from, i.e. physician, hospital, clinic, etc.)

TO RELEASE INFORMATION TO			
Name of Person or Facility			
Address			
Phone #		Fax #	

The Information I authorize disclosed is:

From (date) _____ to (date) _____.

- ☐ Results
- ☐ Reports
- ☐ Physician Notes
- ☐ Entire Record
- ☐ After Visit Summary (AVS)
- ☐ Other _____

I understand that my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.

_____ _____

Signature of Patient or Legal Representative | Date

☐ Parent or Legal Guardian ☐ Next of Kin of Deceased ☐ Power of Attorney ☐ Executor of Estate