Powers HEALTH℠

☐ Quick Release

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, e.g. physician, hospital, clinic, etc.)

TO RELEASE INFORMATION TO			
Name of Person or Facility			
Address			
Telephone Number		Fax Number	

The information I authorize disclosed is: From (date) _____ to (date) _____

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

I understand:

- My health record may include information relating to sexually transmitted diseases, 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 have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management (HIM) Department. The revocation will not apply to information already released in response to this authorization, and it 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.
- Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I may inspect or copy the information to be used or disclosed. Information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
- There may be a fee for copying these records.

I authorize _____ to pick up the requested copies of my record and understand that he/she must be able to prove their identity with a valid driver's license or state identification card.

_____ _____ _____

Signature of Patient or Legal Representative *Date* *Time*

Legal Representative: ☐ Parent ☐ Power of Attorney ☐ Legal Guardian ☐ Executor/Administrator/Personal Representative of Estate

Paperwork Must Be Provided

If the patient is deceased and there is no documentation of a Personal Representative of the Estate:

☐ I attest that there is no Executor/Administrator/Personal Representative of the Estate, and I am the decedent's spouse.

☐ I attest that there is no Executor/Administrator/Personal Representative of the Estate or a spouse, and I am the decedent's child.

☐ Other, Please Explain: _____

☐ I acknowledge that the records I am receiving are **incomplete**. Please initial: _____