HUTCHINSON
REGIONAL PHYSICIAN NETWORK

RI0001

Delivery Options:
❑ Pick up in MRD Date: _____
❑ Mail Date: _____

Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I have the right to receive a copy of this Authorization after I sign it.

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street (Apt. #, PO Box #-as applicable), City, State and Zip code

Phone#: _____ Dates of service/treatment: _____ to: _____

Disclose Information To: _____
Name of Facility/Person Receiving the Information

Fax/Phone of Receiving Facility: _____

Release Information From: _____
Name of Facility/Person Disclosing the Information

Description of information authorized to be released/disclosed:

- ❑ **All Reports below**
- ❑ **All Clinical Notes Only**
- ❑ **History & Physical Exam**
- ❑ **Progress Notes**
- ❑ **Consults**
- ❑ **Oncology Records**
- ❑ **Immunization Record**
- ❑ **Pathology Reports**
- ❑ **Laboratory reports**
- ❑ **Radiology/CD**
- ❑ **All Billing Information Only**

❑ **Other:** _____

Type of Media: ❑ Paper ❑ Electronic on CD (PDF format)

For the following reason(s): ❑ **Legal Purposes** ❑ **Insurance Purposes** ❑ **Work Comp** ❑ **Personal/ Self**

❑ **Continuation of Care** ❑ **Other** _____

Expiration: This Authorization will expire on _____(MM/DD/YY) [cannot exceed one year from date below]. If expiration date is left blank, the authorization shall remain effective for 60 days after the date listed below.

I understand that my medical records (including any psychiatric, alcohol or drug abuse information) are protected by Federal Regulations and cannot be disclosed without written consent unless otherwise provided for in said regulations. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this Authorization at any time by notifying the providing organization in writing but, if I do, it will not have any effect on any actions taken before receiving the revocation.

I have read the above and authorize the disclosure of such health information as described herein. I understand that treatment, payment, enrollment or eligibility for benefits is not conditioned upon the execution of this Authorization.

_____ _____
Signature of patient or patient's representative (Photo identification required) Date

_____ _____
Printed name of Patient or Patient Representative (Provide document to prove authority) Relationship to Patient

_____ _____
Signature of Witness Date