PLATTE VALLEY INTERNAL MEDICINE AND PULMONARY

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Authorization to Release Medical Records/Information

Please complete the following information:

Patient Name: _____ Date of Birth: _____ / _____ / _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (Home) _____ (Cell) _____ (Work)

I authorize _____ to disclose/release the following information.
(Place Releasing Your Records)

Check all that apply:

- ☐ Office Notes (except psychotherapy notes unless authorized below)
- ☐ Xray/Radiology Reports
- ☐ Laboratory/Pathology Reports
- ☐ Billing Records
- ☐ Consults
- ☐ Hospital Notes
- ☐ Other (describe specifically): _____

Note: If these results contain any information from previous providers, you are hereby authorizing disclosure of this information

Disclosure of information about HIV/AIDS status, mental health, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease must be specifically authorized in this box.

HIV/AIDS Mental Health Sexually Transmitted Diseases Alcohol/Drug Abuse

The information may be used/disclosed for each of the following purposes

- ☐ At my request (only the patient can check this box)
- ☐ Continuing Care
- ☐ Changing Physicians
- ☐ Other: _____
- ☐ Workman's Comp
- ☐ For Payment/Insurance
- ☐ Legal

This authorization shall expire no later than ____ / ____ / ____ or upon the following event _____ (whichever is sooner) and may not be valid for greater than one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient's personal representative Relationship to patient