Guadalupe Regional MEDICAL CENTER

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AUTHORIZATION TO RELEASE/ACCESS PROTECTED HEALTH INFORMATION

Patient Name _____

Date of Birth _____ SSN _____ Phone _____

Address _____ City _____ ST _____ Zip _____

I authorize Guadalupe Regional Medical Center, or business associate working on their behalf, to release information contained in the medical record on the patient identified above. Information released/requested will cover the following dates of service: From _____ Through _____

Information Released:

- ☐ Consultation Report
- ☐ Discharge Summary
- ☐ Emergency Room Records
- ☐ Entire record (excludes Psychotherapy notes)
- ☐ Laboratory Reports
- ☐ Operative Report
- ☐ Pathology Reports
- ☐ Other _____
- ☐ Radiology Studies (CD only)
- ☐ Therapy Records

Purpose of Request:

- ☐ Continued Treatment
- ☐ Third Party Payment/Insurance*
- ☐ Legal Review*
- ☐ Personal Review*
- ☐ Other (Specify)* _____

Medical Records will be delivered as follows: (Check only one box)

- ☐ I will pick up copies of my records
- ☐ Records will be picked up by _____ (photo ID required)
- ☐ Provide my records to the **physician/facility** listed below:

Name/Organization	
Address	
Phone	

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked earlier, the expiration date of this Authorization will be 90 days from the date of signature.
- That information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by privacy regulations.
- The information authorized for release may include protected health information related to mental health or substance use/abuse. Release of mental health records or psychotherapy notes my require consent of the treating provider or court order.
- If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or HIV related information; you must specifically authorize the release of such information to the above named recipient
  by initialing: Yes _____ (initial) or No _____ (initial)
- That Guadalupe Regional Medical Center will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization.
- I may request a copy of this signed authorization for my records.

_____ _____ _____

Signature of Patient or Patient's Legal Representative** Relationship to patient Date Signed

*Fees apply **May be required to show proof of representative status