TriState Health

RECORDS REQUEST FORM
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth ____/____/_____ Phone # _____

I hereby authorize _____ (name of facility/person requested to release records) to disclose records obtained in the course of my evaluation and/or treatment to:

Name _____ Address _____

Phone Number _____ Fax Number _____

Records Requested - for pediatric patients

Entire chart

Records Requested - for adult patients

Last year of:
PCP Notes
Specialty/Consults
Labs
Radiology

Most recent:
EGD and Pathology
Colonoscopy and Pathology
Dexa
Mammogram
Pap
Wellness Exam

Unless otherwise indicated, I authorize the release of information regarding testing, treatment and diagnosis, to include: alcohol and drug abuse, sexually transmitted infections, HIV/AIDS, genetics and mental/behavioral health, to include psychotherapy notes.

_____ **DO NOT AUTHORIZE TO INCLUDE THE ABOVE SENSITIVE RECORDS IN THIS RELEASE.**
(Initials)

This authorization is valid until _____ OR when the following event occurs, _____.
If left blank, this authorization shall become invalid and expire 180 days after date signed.

I understand that:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your records. Such re-disclosure will no longer be protected by this authorization. Federal or State laws may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.
2. I have the right to receive a copy of this authorization and there may be a charge for the medical records.
3. A copy or facsimile (fax) of this authorization is as valid as the original.
4. My provider may not condition treatment, payment, enrollment, or eligibility for benefits if I choose not to sign this form.
5. I may revoke this authorization in writing at any time. The only exceptions is when my provider has taken action in reliance on this authorization or the authorization was obtained as a condition of my insurance.

The information that I am requesting may be sent by U.S. Mail Service and/or electronic facsimile in accordance with the hospital's facsimile (fax) policy.

I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.

_____ Relationship _____ Date ___/___/____
Patient, Legal Guardian, or Representative* Signature

_____ Date ___/___/____
Witness Signature

**Authorized representative must submit copies of legal document supporting his or her authorfty to act on the patient's behalf.*

For Office Use Only:

ID verified (initial) _____ Completed by _____ Date completed ___/___/_____

ROI # _____ Medical Record # _____ # of CD's/pages _____ Charge for copies/CD _____ Sales Tax _____