Heart of America medical center

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RELEASE OF INFORMATION

Patient Name: _____ **Phone Number:** _____

Date of Birth: _____/_____/_____ **Social Security Number:** _____

I authorize _____

_____
Address Phone Fax

To release my patient information to (Facility / Provider) _____

_____
Address Phone Fax

Reason:

Continuation of Care ☐ Legal ☐ Personal ☐ Insurance ☐ Other _____

Date of Treatment: from _____ to _____

Information to be disclosed:

Radiology Report ☐ Operative Report ☐ ER Report ☐ EKG / Cardiac ☐ Medications ☐

Radiology Films ☐ Labs ☐ Notes ☐ Other (specify) _____

I authorize the release of records containing the following information:

Mental Health ☐ **Initial** _____ **Date** _____
Substance Abuse ☐ **Initial** _____ **Date** _____
HIV/AIDS ☐ **Initial** _____ **Date** _____
Other_____ **Initial** _____ **Date** _____

Copy Fee: We reserve the right to charge a reasonable fee for the cost of producing and mailing or faxing the copies. The first 25 pages will be $20 with $0.75 for each additional page.

Email: Electronic releases are **not** recommended, but can be done with the understanding that there is no 100% secure electronic release of information. Please consider using our patient portal, MyHealth, for your electronic records. If you still choose to have your records released via email we will only email them to your personal email address.

Personal Email Address: _____

Revocation: I understand that this authorization will remain in effect for 90 days from the date of signature, unless otherwise stated. I also understand that I may revoke this authorization by submitting a written revocation to GSHA; however, this would not apply to any information already disclosed in good faith. To submit a revocation, please contact the HIPAA Privacy Officer. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____/_____/_____
Signature **Date**

_____ _____
Printed Name **Relationship to Patient**

For Facility Use
Completed Initials _____
Date _____ #Pages_____

Updated: 09/05/2018