



1. Patient Name: _____ DOB: ____/____/____

Patient Address: _____ State: _____ Zip Code: _____ Phone: _____

2. I authorize PureView Health Center to Receive my records from ____ Release my records to ____

Individual/Facility/Organization: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

3. Dates: ____/____/____ to ____/____/____ (If time frame is not specified, last 3 visit notes will be provided.)

4. Release to Self: ____ (ID required to pick up in person.)

5. Purpose of Release (check any that apply)

- | | | |
|--|---|---|
| ☐ Personal Use/Review | ☐ Legal | ☐ Other: (please specify) |
| ☐ Transfer of Care (Transferring care from PVHC. Please close my chart.) | ☐ Insurance (Payments/Claims) | _____ |

6. Information to be Released/Received/Discussed (check any that apply)

- | | | |
|---|--|---|
| ☐ Clinic Notes | ☐ Consultation Reports | ☐ Dental Images |
| ☐ Laboratory Tests | ☐ Medication Records | ☐ Other: (please specify) |
| ☐ Pathology Reports | ☐ Immunization/Allergy Records | _____ |
| ☐ Imaging Reports | ☐ Billing | |

7. The records below will be released unless checked: I understand that my protected health information may include information on diagnosis or treatment related to psychiatric or psychological conditions, substance use disorder and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment will be released unless I check the circle below.

- ☐ I do not authorize this information to be released.

8. This authorization expires one year after the date signed unless a different date of expiration is entered here: ____/____/____

This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. PureView Health Center Notice of Privacy Practice describes how to cancel (revoke) this authorization. PureView Health Center will not restrict my treatment if I choose not to sign this authorization. A photocopy/fax of this authorization will be treated in the same way as an original. PureView Health Center cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release PureView Health Center from all liability resulting from a redisclosure by the recipient.

Confidentiality of Alcohol and Drug Abuse Patient Records: Any records disclosed by PureView pursuant to your consent granted by this ROI will contain a notice to the receiving party about further disclosure of the records in one of the following formats: 1) This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see§ 2.31). The federal rules restrict any use of the information to investigate or prosecute regarding a crime any patient with a substance use disorder, except as provided at§§ 2.12(c)5 and 2.65; OR 2) 42 CFR part 2 prohibits unauthorized disclosure of these records.

I authorize PureView Health Center to contact me by phone, text or email. I understand that while PureView will use reasonable safeguards to protect text and email communications, no electronic communication is guaranteed to be secure.

Your signature indicates that you have read and understand this form and authorize release of your information as described above.

9. Patient Signature: _____ Date: _____

Authorized Representative/Witness signature: _____ Date: _____

*If signed by a patient's authorized representative, supporting documentation must accompany this authorization form. *

****For a speedy return of records, please fill out this form completely.****

Authorization to Disclose Patient Health information Directions

For a speedy return of records please fill out this form completely.

1. Complete Name and address information

2. Choose if you would like us to:

Receive your records from

Release your records to

- Next, name the agency or person you are authorizing us to receive, release or discuss your records with.
 - Please provide as much information as possible for out of state requests. If there is no telephone/fax number, it may delay receiving records.
 - If the records are for self, please note you will need to show an ID to pick them up in person.
3. Enter dates of records: Example: 05/03/22 to 05/03/23. Only records for dates entered will be released.
4. Check the purpose of the release.
5. Check which records to release.
6. Check if you do not want any of these records released.
7. Enter an expiration date. If blank, the release will expire one year from date of your signature.
8. Must sign and Date release form.

If any of the information is unclear, we may call you to clarify.

Thank you for your help!

Medical and Dental Records Department