Requesting Medical Records

Authorization to Release or Obtain Health Information

Please complete the entire form.

Patient Name	Request Date
Address	Date of Birth
City/State/Zip	Last four digits of Social Security number
E-mail Address	Phone

I request that my Protected Health Information (PHI) from Daughters of Charity Health Centers be disclosed to:

Recipient's Name	Relationship
Address	Telephone Number
City/State/Zip	Fax Number

Disclosure Format ☐ Mail ☐ Fax ☐ Other (Please specify): _____

The **Purpose of this Authorization** is indicated in the box(es) below.

☐ Further Medical Care ☐ Personal ☐ Research related treatment
☐ Eligibility Determination ☐ Changing Healthcare Provider ☐ Legal Investigation or Action
☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol or drug abuse.

I authorize the release of the following protected health information:

☐ Entire Record ☐ Surgical reports ☐ Immunizations
☐ Medical History, Examination, reports ☐ Treatment or Tests ☐ Prescriptions
☐ Itemized Billing Records ☐ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

☐ Alcohol, Drug, or Substance Abuse ☐ Vocational Rehabilitation ☐ Psychotherapy Notes
☐ Sexually Transmitted Diseases ☐ HIV/AIDS ☐ Other_____
☐ Mental Health ☐ Genetics

Covering the period of healthcare from: Specific Date(s): _____to_____.

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to: Daughters of Charity Health Centers Medical Records Department, _____
- Unless otherwise revoked, this authorization will expire 12 months from the date signed: _____.
- I acknowledge that I have fully read and understand this form.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

For Office Use Only

_____ _____ _____
Health Information Representative Signature Date Patient Number