# AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

neighborcare health

**Please complete this entire form to have your health records processed.**

| CLINIC USE ONLY |
|---|
| MEDICAL RECORDS NUMBER (MRN): |

## PATIENT INFORMATION

| PATIENT NAME | DATE OF BIRTH / / |
|---|---|
| PREVIOUS NAME (IF APPLICABLE) | |

## WHY IS THIS HEALTH INFORMATION BEING RELEASED?

| | | |
|---|---|---|
| ❑ Personal use | ❑ Transfer to another provider | ❑ Continuity of care |
| ❑ Legal use | ❑ Other (please specify): | |

I wish to receive my records ❑ electronically on CD ❑ printed on paper

| INFORMATION TO BE RELEASED **FROM**: | | | INFORMATION TO BE RELEASED **TO**: | | |
|---|---|---|---|---|---|
| ❑ **Neighborcare Health** or ❑ **Other company/organization** | | | ❑ **Neighborcare Health** or ❑ **Other company/organization** | | |
| NAME: | | | NAME: | | |
| ADDRESS: | | | ADDRESS: | | |
| CITY: | STATE: | ZIP: | CITY: | STATE: | ZIP: |
| PHONE: | FAX: | | PHONE: | FAX: | |

## TYPE OF INFORMATION TO BE RELEASED

| | |
|---|---|
| ❑ All medical records | ❑ Medical records for the last two years |
| ❑ Vaccination records | ❑ Verbal communication about patient care only |
| ❑ Other (please specify): | |

## PATIENT AUTHORIZATION

I UNDERSTAND that information released may include information regarding the testing, diagnosis or treatment of mental/psychiatric illness, drug and/or alcohol use, HIV/AIDS, or sexually transmitted diseases. I give authorization for this information to be released.

❑ I do not authorize the release of this information.

## MY RIGHTS AS A NEIGHBORCARE HEALTH PATIENT

**I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).** However, I do have to sign an authorization form:

- To take part in a research study, or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did it would not affect any actions already taken by Neighborcare Health or the organization indicated above. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

**This authorization will expire one year from the date signed below unless otherwise listed: _____/_____/_____.**

## SIGNATURE OF PATIENT/ LEGAL AUTHORITY

**Documentation may be required to prove authority to sign on behalf of the patient.**

| SIGNATURE OF PATIENT/ LEGAL AUTHORITY | RELATIONSHIP TO PATIENT (if other than self) | DATE / / |
|---|---|---|

## MINORS AGES 13–17

**A minor between the ages of 13–17 is required to sign this release as well to transfer records.**

| SIGNATURE OF MINOR | DATE / / |
|---|---|

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