MERITUS HEALTH

AUTHORIZATION FOR RELEASE OF PATIENT IDENTIFIABLE HEALTH INFORMATION

Date of Request: _____ Medical Record Number: _____

Patient Name: _____ Birthdate: _____

Full Address: _____ Phone #: _____

☐ **Release a Copy of My Health Information to Me**

☐ **I Authorize Release of My Health Information to:**

_____

Name of Other Person, Third-Party, or Entity

_____

Full Address Telephone Number Fax Number

Information to be released/copied/provided is from the following time(s):

☐ Location/Office Name _____
☐ All Dates of Service _____
☐ Inpatient, Dates of Stay _____
☐ Office Visit Date(s) _____
☐ Outpatient Date(s) _____
☐ Urgent Care Date(s) _____
☐ Emergency Department Date(s) _____
☐ Other (specify) _____

Specific information to be released/copied/provided include the following:

☐ Entire Record _____
☐ Lab Results, X-Ray Reports, Test Results (specify) _____
☐ Surgical Records, Operative Notes _____
☐ Immunization Records _____
☐ Progress Notes _____
☐ Discharge Summary _____
☐ History & Physical _____
☐ Pathology Reports _____
☐ Prescription Medication(s) _____
☐ Other (specify) _____

Confidential Information to be excluded from the Health Information that is released/copied/provided:

☐ Drug or Substance Abuse, or Alcoholism Diagnosis/Treatment (specify) _____
☐ Behavioral Health Records, Diagnosis/Treatment (specify) _____
☐ Sexually Transmitted Disease or AIDS/HIV Diagnosis/Treatment _____
☐ Other Limitations (specify) _____

This Health Information is needed for:

☐ Personal Use ☐ Continuing Medical Care ☐ School ☐ Insurance
☐ Legal Reasons ☐ Social Security/Disability ☐ Military ☐ Other

PLACE LABEL HERE

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I understand that unless I specifically request for such information to be excluded from the authorized release on this Authorization form, the items in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

I also understand that unless I specifically request for such information to be excluded from the authorized release on this Authorization form, it may include information about history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease.

I understand that the person giving authorization may revoke this authorization by a written and dated notice to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization expires one year from the date of signature, unless I specify otherwise or revoke it. I understand that I may be charged for copies of my medical records according to applicable state and federal laws and guidelines. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

I understand that authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____

Print Patient Name **Date**

_____

Patient Signature **Date**

_____

Signature of Parent/Executor/Legal Representative **Date**

PLACE LABEL HERE