Medical Records Release Form

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT INFORMATION *(please print in all sections of the document)*	
Patient Name:	Previous Name(s):
Date of Birth:	Social Security:
Address:	City/State/Zip:
Phone:	Email:

MY AUTHORIZATION

I voluntarily consent to and authorize Hope Health to:

Check one: ☐ **Release My Health Care Information To:** ☐ **Obtain My Health Care Information From:**

(Note: if the patient is requesting a copy of their own medical records, check "Release My Health Care Information To" and write in patient's personal information below)

Name or Organization:	Phone:
Address:	City/State/Zip:

PURPOSE *(I authorize the release of my health information for the following purpose)*

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

INFORMATION TO BE DISCLOSED

☐ **All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, and any treatment received by me.**

☐ **Dental Records:**

☐ **Only the following records or types of health information** *(list below):*

_____

TERM *(I understand that this authorization will remain in effect based on the selection below)*

☐ **From the date of this Authorization until the** _____ day of _____, 20_____

☐ **Until the Provider fulfills this request**

☐ **Until the following event occurs:** _____

REDISCLOSURE

I understand that Hope Health cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

REFUSAL TO SIGN/RIGHT TO REVOKE

I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Hope Health. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Hope Health. The revocation will be effective immediately upon Hope Health's receipt of my written notice, except that the revocation will not have any effect on any action taken by Hope Health in reliance on this Authorization before it received my written notice of revocation.

QUESTIONS

I may contact Hope Health for answers to my questions about the privacy of my health information by telephone at ***(972) 923-2440***, email at ***info@hopehealthtx.org*** or in person at the Waxahachie or Ennis location

SPECIFIC AUTHORIZATIONS

Sexually Transmitted Disease (STD) as defined by law, includes Herpes, Herpes Simplex Virus, Human Papilloma Virus, Condyloma (genital warts), Chlamydia, Non-specific Urethritis, Syphilis, VDRL, Chancroid, Lymphogranuloma Venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and Gonorrhea.

☐ **Yes** ☐ **No** I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ **Yes** ☐ **No** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

FEES

Hope Health strongly encourages the receipt of medical records through fax/email to prevent fees associated with printing. If medical records are released directly to the patient in the form of a paper copy, a fee of $10.00 for the first 20 pages and $0.20 for each additional page will be charged.

REQUIRED SIGNATURES

_____	_____	_____
Patient Name (please print)	Signature of Patient	Date

If patient is unable to sign this authorization, please complete the information below:

_____	_____	_____
Name of Guardian/Representative	Legal Relationship	Signature

INTERNAL USE ONLY

This section is to be completed by the Hope Health employee who verifies the identity of the Patient, Guardian or Representative signing this form.

_____	_____	_____
Name of Witness (please print)	Signature	Date