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AUTHORIZATION FOR USE AND RELEASE OF HEALTH RECORDS

Release of Information

Patient's Full Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Medical Record No:** _____

RELEASE OF GENERAL HEALTH RECORDS

I AUTHORIZE PRESBYTERIAN HEALTHCARE SERVICES ("PRESBYTERIAN") TO USE OR RELEASE (DISCLOSE) THE FOLLOWING HEALTH RECORDS OF THE ABOVE NAMED PATIENT ("PATIENT").

☐ Dictated Reports ☐ Test Results ☐ Billing Records ☐ All Health Records
☐ Other (Please specify) _____

From (indicate facility): _____

For date(s) of service from: _____ to _____

To (Name): _____

Address: _____ City: _____

State: _____ Zipcode: _____ Telephone Number: _____ Facsimile (FAX) Number: _____

Records released for the following purpose(s): ☐ Pick Up ☐ Mail Out

☐ At the request of the Individual
☐ For Marketing (specify campaign): _____
☐ If checked, Presbyterian will receive direct or indirect payment from a third party as a result of this activity.
☐ Other (Describe each purpose of the requested use or disclosure)

IN ADDITION TO RELEASE OF THE GENERAL HEALTH RECORDS INDICATED ABOVE, BY INITIALING BELOW I ALSO AUTHORIZE THE RELEASE OF HEALTH RECORDS PERTAINING TO THE FOLLOWING CONDITIONS.

(Initial ONLY those records to be released):

_____ Health Records Related to Drug / Alcohol / Substance Abuse
_____ Health Records Related to Sexually Transmitted Diseases
_____ Health Records Related to Human Immune Deficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS)
_____ Health Records Related to Emotional / Mental Health / Developmental Disabilities / Psychiatric Conditions
(Excludes Psychotherapy Notes. This authorization does not authorize release of Psychotherapy Notes. To release Psychotherapy Notes, a separate authorization is required.)

EXPIRATION: I understand that I may cancel this authorization at any time by sending Presbyterian my notice of cancellation in writing. I understand that Presbyterian may have already used or released records according to this authorization prior to receiving my notice of cancellation. I understand that if this authorization is cancelled, an insurer may still have the legal right to contest a claim or the insurance policy. This right only applies if this authorization is requested as a condition of obtaining insurance coverage. **UNLESS CANCELLED, THIS AUTHORIZATION EXPIRES (either Event OR Date is required):**

☐ In 6 months ☐ When Other Event occurs (specify): _____
OR on Date: _____ *If not otherwise designated this authorization will expire 12 months from date signed.

IN THE EVENT OF MY DEATH: I authorize the following persons to obtain my medical records as indicated above: _____
_____ Or ___ I do not wish to authorize release of my records in the event of my death.

I UNDERSTAND THAT THIS AUTHORIZATION TO RELEASE HEALTH RECORDS IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF PATIENT RECEIVING TREATMENT OR PAYMENT FOR SERVICES, EXCEPT AS PERMITTED BY LAW. I have read and understand this authorization form including statements that appear on the reverse side of this page. I am the Patient or I am legally authorized as the Patient's representative to execute this authorization and accept these terms.

_____ _____ _____
Patient or Authorized Representative/Relationship to Patient Date Time
(Relationship to Patient required if signed by Representative)

_____
Print Name if Other than Patient

PATIENT IDENTIFICATION

PRESBYTERIAN

White Copy - Chart Canary Copy - Patient

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RIGHT TO REVIEW: By law, you have a right to see and obtain a copy of the information to be disclosed under this authorization.

FEES: We charge a fee for providing a copy, summary or explanation of the information you request. Before we provide the requested information, we will tell you how much it will cost. You may change your request to avoid or reduce the fee.

DENIAL OF REQUEST: We may deny your request to release your health records only for certain reasons. If your request is denied, you may request a review of this decision as described in Presbyterian's *Notice of Privacy Practices*.

REDISCLOSURE OF INFORMATION: I understand that information released under this authorization could potentially be redisclosed by the receiver of the information. If information is redisclosed by the receiver, the information may no longer be protected under federal privacy law. I understand that Presbyterian cannot prevent the person who receives this information from releasing it to others.

PHYSICIAN RECORDS: I understand that physicians (such as radiologists, anesthesiologists and pathologists) provide services in Presbyterian facilities but may not be employees or agents of Presbyterian. These physicians may maintain additional health records about the Patient (such as billing records). To release information contained in those records the Patient must contact the physician.

CERTIFICATIONS: I certify that prior to signing this authorization all blanks or statements requiring completion by me were filled in and all items that do not apply were left blank. I release Presbyterian Healthcare Services its officers, directors, employees and agents and the physicians who provided Patient's healthcare services from all liability and claims of any nature that may arise from the release of information requested under this authorization.

A copy of this authorization that contains my signature shall be considered as effective and as valid as the original and shall be honored by those to whom it is provided.

AUTHORIZATION FOR USE AND RELEASE OF HEALTH RECORDS

Release of Information

1 **Patient's Full Name:** Mary Jane Doe SAMPLE

2 **Date of Birth:** MM/DD/YYYY

3 **Social Security Number:** xxx-xx-xxxx

4 **Medical Record No:** _____

5 RELEASE OF GENERAL HEALTH RECORDS

I AUTHORIZE PRESBYTERIAN HEALTHCARE SERVICES ("PRESBYTERIAN") TO USE OR RELEASE (DISCLOSE) THE FOLLOWING HEALTH RECORDS OF THE ABOVE NAMED PATIENT ("PATIENT").

6 ☐ Dictated Reports 7 ☐ Test Results 8 ☐ Billing Records 9 ☐ All Health Records

10 ☐ Other (Please specify) _____

From (indicate facility): 11 _____

For date(s) of service from: 12 _____ to _____

To (Name): 13 _____

14 Address: _____ City: _____

State: _____ Zipcode: _____ Telephone Number: _____ Facsimile (FAX) Number: _____

Records released for the following purpose(s): 15 ☐ Pick Up ☐ Mail Out

16 ☐ At the request of the Individual

17 ☐ For Marketing (specify campaign): FOR PRESBYTERIAN USE ONLY

☐ If checked, Presbyterian will receive direct or indirect payment from a third party as a result of this activity.

18 ☐ Other (Describe each purpose of the requested use or disclosure)

_____

IN ADDITION TO RELEASE OF THE GENERAL HEALTH RECORDS INDICATED ABOVE, BY INITIALING BELOW I ALSO AUTHORIZE THE RELEASE OF HEALTH RECORDS PERTAINING TO THE FOLLOWING CONDITIONS.

(Initial ONLY those records to be released): 19

_____ Health Records Related to Drug / Alcohol / Substance Abuse

_____ Health Records Related to Sexually Transmitted Diseases

_____ Health Records Related to Human Immune Deficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS)

_____ Health Records Related to Emotional / Mental Health / Developmental Disabilities / Psychiatric Conditions
(Excludes Psychotherapy Notes. This authorization does not authorize release of Psychotherapy Notes. To release Psychotherapy Notes, a separate authorization is required.)

20 **EXPIRATION:** I understand that I may cancel this authorization at any time by sending Presbyterian my notice of cancellation in writing. I understand that Presbyterian may have already used or released records according to this authorization prior to receiving my notice of cancellation. I understand that if this authorization is cancelled, an insurer may still have the legal right to contest a claim or the insurance policy. This right only applies if this authorization is requested as a condition of obtaining insurance coverage. **UNLESS CANCELLED, THIS AUTHORIZATION EXPIRES (either Event OR Date is required):**

☐ In 6 months ☐ When Other Event occurs (specify): _____

OR on Date: Not to exceed 5 years

21 **IN THE EVENT OF MY DEATH:** I authorize the following persons to obtain my medical records as indicated above: _____

_____ Or ___ I do not wish to authorize release of my records in the event of my death.

I UNDERSTAND THAT THIS AUTHORIZATION TO RELEASE HEALTH RECORDS IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF PATIENT RECEIVING TREATMENT OR PAYMENT FOR SERVICES, EXCEPT AS PERMITTED BY LAW. I have read and understand this authorization form including statements that appear on the reverse side of this page. I am the Patient or I am legally authorized as the Patient's representative to execute this authorization and accept these terms.

22 SAMPLE _____ 23 _____ 24 _____

Patient or Authorized Representative/Relationship to Patient — Date — Time

(Relationship to Patient required if signed by Representative)

25 _____

Print Name if Other than Patient

PATIENT IDENTIFICATION

PRESBYTERIAN

White Copy - Chart Canary Copy - Patient

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See next page for instructions on completing this form.

Instructions for completing the **Authorization for Use and Release of Health Records** form

1. **Patient's Full Name**
   Clearly print your first, middle and last name.
2. **Date of Birth**
   Enter your birth date in this format: MM/DD/YYYY
3. **Social Security Number**
   Enter your complete social security number (XXX-XX-XXXX).
4. **Medical Record No**
   This will be completed by Presbyterian staff.
5. **Release of General Health Records**
   This information will tell us what records you want released and where we should send them.
6. **Dictated Reports**
   Check this box for reports such as: History and Physical, Consultant reports, Operative/ Surgical report, Discharge Summary report.
7. **Test Results**
   Check this box for: Lab reports, blood work, diagnostic tests, radiology reports.
8. **Billing Records**
9. **All Health Records**
   This includes all Dictated Reports and Test Results plus nursing notes, progress notes, provider orders, social services and therapy visits. There is NO CHARGE for records sent directly to a healthcare provider. Please note: There is a charge for copies requested for other purposes. Many requests can exceed 100 pages when copied. You can request an estimated bill with your request.
10. **Other**
    Please specify the record(s) you want released.
11. **From (indicate facility)**
    Please tell us the name of the Presbyterian facility (hospital, clinic, etc.) where you received services so we can retrieve your records.
12. **For date(s) of service from**
    Please tell us the approximate time period (if known) when you received services for which you are requesting records.
13. **To (Name)**
    Tell us the individual, practice or company where you want your records sent.
14. **Address, City, State, Zip code, phone and fax number**
    Tell us the complete address, phone and fax number of the individual, practice or company where you want your records sent.
15. **Pick up or mail out**
    Please check if you will pick up the records or want us to mail them. Please note: We send records directly to the care provider for continuing care.
16. **At the request of the individual**
    These copies will be provided for a fee.
17. **For Marketing**
    This is used by Presbyterian staff only.
18. **Other**
    Please describe the purpose of the requested use or disclosure.
19. If you are requesting release of records related to the specific healthcare services listed on the form, please initial by the appropriate record types.
20. **Expiration**
    You may specify how long you want this Authorization to be in effect by either noting a date or when an event occurs. For example, "Not to exceed 5 years."
21. **In the event of my death**
    This is to make your choice of Personal Representative known. Your Personal Representative will receive your health records after your death. The State of New Mexico requires a Personal Representative be selected for your health records even if you have a surviving spouse.
22. **Your signature or Authorized Representative**
    Please sign; if your authorized representative signs, please note the relationship to the patient.
23. **Today's date**
24. **Time of signature**
25. **Print name if other than patient**
    The Authorized Representative.

PRESBYTERIAN