Authorization to Release and Disclose Patient Information

To treat you effectively, your provider needs to review your past medical records. For questions about transferring records to or from Heartland, contact Heartland's Health Information Management Department at 785-841-7297 ext. 266.

Last Name:________________________________ First Name:________________________ Middle Initial:_______________
Other Names Used:________________________ DOB:____
Address:__________________________________ City:________________ State:_________ Zip:__________
Home Phone:______________________________ Mobile Phone:____________________________________

I hereby request access to the protected health information in my electronic health record for dates of service from (date):___________________ to (date):_______________ maintained or created by the provider named below to the recipient named below.

☐ Most Recent Medical Progress Notes
☐ Most Recent Dental Progress Notes
☐ Most Recent Pap/Mammogram/Colonoscopy results
☐ Billing Record
☐ Immunization
☐ X-ray Reports/Films
☐ Pathology/Lab Reports
☐ Other: __________________________________
☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an Individual's Health Information must be completed to obtain additional records)

☐ I will pick up my records
☐ Mail Copies of my records to the individual noted below
☐ Fax my records to: ____________________

Records From	Records To
Name:	**Name**:
Address:	**Address**:
Phone:	**Phone**:
Fax:	**Fax**:

Purpose of Request: ☐ Patient's Request ☐ Insurance Dispute ☐Referral ☐Other:___________________________________

I understand:

- I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature
- Heartland Community Health Center will not restrict my treatment if I choose not to sign this authorization
- A photocopy/fax of this authorization will be treated as an original
- Heartland Community Health Center records may include records that it received from other organizations. If these records have been used by Heartland and filed in the records Heartland maintains about you, these records could possibly be released with the patient's health records.
- Heartland cannot prevent re-disclosure of the patient's information by the person or organization who receives your records under this authorization, and that information may not be covered by state and Federal privacy protections after its been released. By signing this authorization, you release Heartland from any and all liability resulting from a re-disclosure by the recipient.
- Re-disclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing. Other laws, however, may prohibit re-disclosure.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE**
- *The information authorized for release may include protected health information or treatment notes related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order
- The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.

______________________________ ______________________________ ______________________
Signature Relationship to Patient Date

______________________________ ______________________________ ______________________
Witness Relationship to Patient Date