AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize CommUnityCare to ***release/obtain*** (circle one) medical information concerning:

Patient Name_____Date of Birth_____Soc. Sec. No. XXX-XX-_____

Address_____Dates of Service_____

City_____State_____Zip_____Telephone Number_____

This information is to be *released to/obtained from* (circle one)**:**

Name_____

Address_____

City/State_____Zip_____Telephone #_____

Return address for CommUnityCare:

_____

_____

_____

Please release the following information, indicated by an "X":

- ☐ Office Visit Notes
- ☐ Lab Results
- ☐ X-Ray results
- ☐ X-Ray Films
- ☐ Immunization record
- ☐ Medication Record
- ☐ Dental
- ☐ Dental films
- ☐ Consultation Reports
- ☐ Tuberculosis Elimination Records
- ☐ Outside records
- ☐ Other specify_____

Your initials are required to release the following information: **INITIAL**

- ☐ **HIV Medical Information** _____
- ☐ **Behavioral Health Records (Psychiatric)** _____
- ☐ **Substance Abuse Records** _____
- ☐ **Genetic information (including genetic test results)** _____

This information is necessary for the following purposes:

___Follow-up Care ____ Patient is requesting disclosure ___Disability Benefits ___Attorney

___Other Please Explain_____

Will financial/compensation result in use or disclosure? ☐ Yes ☐ No

Please release my information via: ___Mail ___Pick-up Format: _____ Paper ___Electronic (CD)

_____ Fax (To Providers or Emergencies Only) (Fax No._____)

The patient or the patient's representative must read the following statements:

I, the undersigned, understand that I may revoke this consent at any time in writing by completing the revocation authorization form, except to the extent that action has been taken in reliance on it and that in any event this consent shall expires 12 months from when it is signed unless otherwise specified (Otherwise specified date_____). I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, CommUnityCare can no longer use or disclose my information for the above purposes without a new authorization. All revocations will be sent to the CommUnityCare return address listed above.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by Federal confidentiality rules.

I understand any of the above requested information may include results of sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.

I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

If form is not complete we may be unable to fulfill this request.

TO THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

_____ _____ _____

SIGNATURE of Patient or Authorized Party Date **RELATIONSHIP** to Patient

WITNESS_____ **REASON** Patient is not signing_____