Authorization for Release of Individually Identifiable Health Information

MRN: _____

Patient Name: _____ DOB: _____/_____/_____ Phone: (_____) _____-_____

I authorize HMG to *release* copies of my record *to*:

Name of Person, Physician or Organization, etc.

Address

City, State, Zip

I authorize HMG to *obtain* copies of my records *from*:

Name of Physician or Institution, etc.

Address

City, State, Zip

****Please Check All That Apply:**

****Information to be Released:**

_____ Entire Medical Record

_____ Last Five (5) Years of Medical Records

****Specific Date Range that includes the following documents from _____/_____/_____ to _____/_____/_____.**

_____Immunization Record

_____ Office Notes

_____ Radiology Reports

_____ Lab Results

_____ Other: _____

PLEASE SEND REQUESTED RECORDS TO HMG

HMG Office: _____

Address: _____

City/State/Zip: _____

Telephone: (_____) _____-_____

****Information will be used/disclosed for the following purpose(s):**

_____ Continuation of Care (for another Provider)

_____ Personal Use

_____ Other:_____

**** Please provide records in the following format:** ☐ Paper ☐ USB / Thumb Drive ☐ Email from ROI Vendor

Email Address (must be legible for processing) _____

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

_____ 1. I understand that the information in my health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about psychiatric services, and treatment for alcohol and drug abuse.

_____ 2. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

_____ 3. I understand that I may revoke this authorization at any time by notifying *HMG* in writing. If I do revoke the authorization, it will not have any effect on any actions taken by *HMG* prior to their receipt of the revocation. Unless otherwise noted, I understand this authorization will expire 90 days from the date of my signature.

Holston Medical Group uses a contracted release of information (ROI) vendor and fees are associated for copies of medical records unless sent to another healthcare facility for continuation of care. All fees are billed by the ROI vendor.

I hereby authorize the use or disclosure of my individually identifiable health information as described above.

I understand that this authorization is voluntary. I also understand the disclosed information may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I also understand that there will be fees associated with any release of information that is not sent to another healthcare facility as continuation of care.

_____ _____/_____/_____

Signature of Patient or Patient's Representative **Date:**

_____ _____

Printed name of Patient or Patient's Representative **Relationship to Patient**

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
ان ت بـ اه : إذا ك ذ ت ب حاجة إل ى خدمات ال ل غة أو ال تـ رجمة، ي رجى أن ت ط لـ ب ال تـ حدث مع مدي ر م ك تـ ب .

***For Internal Use Only:* Photo ID provided ☐ Yes ☐ No**
Attach a copy of Photo ID to form used to the validate signature.

1/2/2018