

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Phone: _____

Request records from:

Name (Provider or Location): _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Phone: _____

Release records to:

Name (Provider or Location): _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Phone: _____

Purpose for request: ___ Insurance ___ Personal ___ Employment ___ Transfer of Care ___ Continuity of Care
Other _____

Information to be shared:

Dates of Service (specific dates) From: _____ To: _____
___ **Complete Record** ___ Radiology Film/Media ___ Radiology Reports ___ ER Record ___ Lab/Path Reports
___ Immunization Record ___ Financial Record ___ Discharge Summary ___ Operative/Procedure Report
___ History and Physical ___ Office/Clerical Notes ___ Specialty Clinic Record ___ Chemical Dependency Evaluation Assessment
___ Other _____

I understand the information in my health record may include information relating to sexually transmitted disease, mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records ___ No ___ Yes Date: _____
Mental Health Records ___ No ___ Yes Date: _____

Disclosure Format ___ Mail ___ Fax ___ USB ___ CD ___ Encrypted Email
___ Unsecured Email (I understand information in this format is at risk for unintentional access by a third party)
Unless otherwise revoked, this authorization expires on the following date/event/condition: _____

By completing this authorization, I agree I have read and understand the definitions outlined on the reverse side of this form:

Patient or Legal Representative Signature Date Time

Print Name Relationship to Patient (if applicable)

Witness Signature for Patient Unable to Sign

Bryan Health

PATIENT REQUEST TO OBTAIN HEALTH INFORMATION FROM ANOTHER FACILITY



Place Patient Label Here

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Release of Information Department at the facility at which the request was made. Revocation will not apply to information that has already been disclosed in response to this authorization.
- If I fail to specify an expiration date/event/condition, this authorization expires one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- This information has been disclosed to you from records which may be protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as 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.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditional on whether I sign this authorization.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.