SHIFA HEALTH

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

FROM THE HEALTH RECORDS OF:

Patient name: ____ DOB: _________________________

Phone #: __________________________ Are you authorizing the release of your own records? __ Yes __ No

If not, what is your relationship to the patient: ____

INFORMATION TO BE RELEASED **BY:**	INFORMATION TO BE RELEASED **TO:**
____ Facility/Doctor/Person name ____ Street address City, State, Zip ____ Phone Fax	____ Facility/Doctor/Person name ____ Street address City, State, Zip ____ Phone Fax

TO RELEASE:

__ Chart notes (Please specify date range): _____________________

__ Diagnosis __ Medicine List __ Labs __ All Records __ Other (specify) _________

DO NOT INCLUDE: ____initial _____

FOR THE PURPOSE OF:

___ Continuation of Care ___ Coordination of Care ___ Transfer of Care ___ Legal

___ Patient Request ___ Other (please specify) _____________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, and/or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing or treatment unless specifically excluded above.

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, pregnancy termination, sterilization and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older) and (3) mental health conditions (age 13 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person of entity named above. I understand I can revoke this form at any time in writing. I understand that my healthcare information is protected by state and federal regulations. I understand that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I understand I do not have to sign this form to receive care and I am entitled to a copy of this form at the time of signing. I understand that if I request records for personal use, to hand carry to another provider or for parties not involved in my healthcare, there will be a charge. There is no charge to release to another healthcare provider. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. This authorization will expire in one year from date signed unless otherwise specified.

____________________________________ ________________________ __________________________________

Patient Signature Date Relationship if other than patient