Authorization to Release Health Information - ROI

RELEASE FROM

Facility/Practice Name: _____ Telephone #: _____

Facility/Practice Address: _____ Fax #: _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

PATIENT INFORMATION

Name of Patient (F,M, L)_____DOB _____

Address_____

City, State, Zip _____Phone _____

INFORMATION TO BE RELEASED

☐ Entire record ☐ Financial records ☐ Office visit notes

☐ Marketing* ☐ On site record review by the patient

☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.

☐ Diagnostic studies (list):

☐ Other as listed ☐ Appointment Information ☐ Billing Information ☐ H& P Notes

☐ _____ ☐ _____

*Financial compensation is received for this communication.

RELEASE TO:

Name _____

Address_____

City, State, Zip _____Phone _____

PATIENT'S RIGHTS AND SIGNATURE:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

PRINT NAME (Patient/Authorized Representative): _____

_____Date _____

Signature of Patient or Authorized Representative

_____

Description of Authorized Representative's Authority and relationship to patient (attach necessary documentation)

For Gaston Family Health Services Use Only: GFHS Employee Please Complete

☐ Identification Verified ☐ Copy of Authorization given to patient
Date of release: _____ via ☐ Mail ☐Fax ☐ Other _____

☐ Accepted – Released information as described above
☐ Partially Accepted - Describe patient information not released: _____
_____

Employee Name & Title _____

Employee Signature: _____