Health Information Release

I authorize the following Facility: ____

Address: ____

Phone #: ______________________________ Fax #: ______________________________

To release the information from the record of:

Patient Name: ___________________________ SSN/Medical Record Number: _____________

Date of Birth: ______________________________Daytime Phone Number: ________________

Address: ____

Documentation can be released electronically if stored in an electronic media.
Please check with your facility to determine if your health information is a candidate for electronic release.

The following information will be released with your electronic visit summary

☐ **Physician/provider visit documentation (from date ______________ to date ______________)** ☐ **Laboratory Results (from date ______________ to date ______________)** ☐ **X-ray Results (from date ______________ to date ______________)**	☐ **Medication List** ☐ **Immunization Record** ☐ **Other:** _______________ _____________________________ _____________________________ _____________________________	**For the purpose of:** ☐ **Verbal Communication** ☐ **Copies of Medical Records** ☐ **Continuity of Care**

1. I understand that the information in my health record might include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, genetic testing, and treatment for alcohol and drug abuse. This information will be released unless otherwise indicated:

Do not release: __________**(Initial)**

2. The following information may be sent/disclosed to the below facility / office:

Facility Name: ____

Address: ____

Phone #: _______________________________________ **Fax #**: _____________________________

3. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If Pratt Medical Center, Ltd. (dba Pratt Healthcare) requested the disclosure, please circle **will** or **will not** in the following sentence:

Pratt will/will not be remunerated for this disclosure.

____ **(Initial) Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulation.**

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about my health information, I can contact Pratt Medical Center Ltd.'s Health Information Department at: (540) 785-7768.

- Parent or Legal Guardian
- Power of Attorney
- Next of Kin/ Deceased
- Executor of Estate

____ _______________________________

Signature of Patient or Legal Representative Date

Revised (6/2018)