KEYSTONE HEALTH CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL/ DENTAL RECORD INFORMATION

Patient Name: _____ **DOB**: _____ Gender ☐ M ☐F

Address: _____ **Phone :** _____

_____

PERSON OR ENTITY AUTHORIZED TO RELEASE INFORMATION:

_____

Address: _____**Phone:** _____

_____**Fax:** _____

PERSON OR ENTITY AUTHORIZED TO RECEIVE INFORMATION:

_____

Address: _____**Phone:** _____

_____**Fax:** _____

Information to be Released/Received: ☐ **Electronic Medical Record** (last 3 years) ☐ **Dental Record** (may be charged fee for x-ray copies)

OR/ Specific Service Dates: From:_____ To: _____ to include the following:

Specific information Requested: _____

_____

_____

_____

Medical Copy Includes: patient chart summary *(which includes)*, medications, allergies, immunizations and chronic problems. Office notes, lab and testing results, inpatient and outpatient consult notes and records from previous physicians. A **Medical Copy** may include information from Keystone Family Medicine, Keystone Audiology and Speech, Keystone Internal Medicine, Keystone Women's Care, Keystone Pediatrics, HIV, Keystone Behavioral Health, Keystone Family Planning/Outreach, Crisis, Keystone Urgent Care, Keystone Infectious Disease and Keystone Dental **** Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules*.***

Format: ☐ **Electronic Media/USB** (one copy at no charge) ☐ **Paper** (KHC fee charged)

Special Records: I understand documentation regarding my diagnosis or treatment for, psychiatric care, drug/alcohol, AIDS/HIV, sexual abuse/assault and reproductive health, may be released as part of my health information, ***(unless the specific boxes below are checked indicating to exclude this information.***
Indicating exclusion reduces the amount of information that can be released and potentially places you at risk...)

AIDS/HIV Information	Psychiatric Care/Treatment	Drug/Alcohol Treatment	Sexual Abuse/Assault Counseling & Reproductive Health
☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose	☐ No, do not disclose

X Patient initials _____ **(initials must be present to release)**

Purpose of Request: ☐ Verbal Exchange ☐ Continuity of care ☐ Transfer of care ☐ Legal Reason_____
☐ Moving ☐ Unhappy with care ☐ Insurance Reason ☐ Personal use ☐ Other_____

Authorization: I hereby authorize Keystone Health Center to disclose/obtain the health information described above. *I understand I may revoke this authorization at any time by notifying the Facility's Privacy Officer in writing of my revocation. *I understand that revocation will not have any effect on actions the Practice took before the revocation. This authorization is voluntary.* I understand that my treatment or payment for services will not be effected if I do not sign this authorization.
I understand that if this organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations. I understand once I take possession of the requested copy, it is then my responsibility to safeguard the Protected Health Information.

*This Authorization will expire: ☐ ____/_____/_____ ☐ Event _____ ☐ One Year, unless otherwise specified.
☐ This authorization will expire 90 days after the date of this request.

_____ _____
Signature of patient or personal representative (Patient 14 years of age or older must sign) Date

_____ _____
Relationship to personal representative of patient Date

_____ _____
Signature of Parent (or legal guardian) Date

Staff Initials_____ Date _____