

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

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 a uthorization 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 _____