

Instructions for Completing an Authorization to Release Protected Health Information

Obtain the form from the Release of Information Departments or via the ProHealth Care website. Please read the entire form to understand your rights. All items must be answered completely in ink.

Patient Name, Date of Birth, Address, and Phone Number:

Accurately enter the patient's demographic information.

Authorizes Disclosure by:

Indicate the facility you are seeking medical records from.

Disclosure of Health Information to:

Enter the Name, Address, City, State, and Zip of where the records are to be mailed.

Information to be Disclosed:

The form is divided into Clinic Records and Hospital Records. Check the documents that you are requesting. If what you are looking for is not listed, check the "Other" box and write in the information.

Disclosures Requiring Special Consent:

State and federal laws protect records regarding HIV, Substance Abuse, and Mental Health at a higher level. If there is information listed in this section that you want released to the person please indicate by checking the appropriate box, otherwise, leave blank.

For the Following Dates:

Enter the dates of service you are requesting records.

Purpose for Disclosure:

Check the reason for the request. If the reason is not listed, check the "Other" box and write in the reason. In addition, check the format you wish to receive the records in and how the records will be released.

Your Rights with Respect to this Authorization:

Please read through this section.

Expiration Date:

Enter date you wish the authorization to expire. If no date entered, authorization will expire in 6 months. Check box and initial.

Signature of Patient:

The patient must sign the authorization unless one of the following applies:

- Patient is incapacitated: Statement of Incapacitation signed by two physicians must accompany the authorization which can be signed by the Power of Attorney for Healthcare or spouse.
- If there is no Power of Attorney for Healthcare or spouse, any member of the immediate family may sign.

- Patient is deceased: The surviving spouse must sign. If there is not a surviving spouse, any member of the immediate family may sign.
- Patient has a Legal Guardian: The legal guardian appointed in a court of law must sign.
- Patient is a Minor: Either of the parents may sign as long as they were not denied parental rights by a court of law. Release of sensitive information varies based on diagnosis and age. In some circumstances, the minor's signature is required for release of records; in others, the parent's signature is required for release of records.
 - Other exceptions apply to minor records and are handled on a case-by-case basis.

If the authorization is not signed by the patient, please indicate the relationship to the patient.

*Please note: Spouse, step-parents, foster parents, birth parents of children placed for adoption, personal representatives, and durable power of attorneys are not authorized to sign for copies of records.

Date and Time:

Enter the date and time you are signing the form.