CHEMED

CENTER FOR HEALTH EDUCATION MEDICINE & DENTISTRY

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient Information	Name: _____ Date of Birth: _____
Receiving Party (*Where do you want the information sent? Who may have the information?)*	Name: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____ □ Fax to _____ □ Email to _____ I would like the information to be sent or disclosed: □ By First Class Mail □ By Facsimile □ By Email □ Verbally to the Receiving Party noted above with phone number: _____

Information to be Released (*What do you want sent or released? Check the appropriate box(es).*)	**Choose one:** □ Complete health record, including (initial if the following apply): ____ All substance use disorder treatment records, including ALL of the items below in this box ____ All HIV-related information ____ All behavioral health treatment information ____ Genetic Testing information □ **Only the items checked below.** □ Demographic information (incl. identification and status as a CHEMED program patient) □ Diagnosis and related information □ History & physical/Bio/Psycho/Social Assessment □ Dates of admission, services and discharge □ Treatment plans(s) □ Types and frequency of services □ Discharge summary □ Transition/after care/discharge plan □ Provider notes and consultation reports (excluding psychotherapy notes) □ Test results and reports (other than toxicology) □ Prescription regimen/dosing Records □ Billing records □ Behavioral health treatment information (including substance abuse treatment information, if applicable). If you would like to limit the dates of service to be provided, list dates of service here: Dates of Service from: _____ to: _____
Purpose for Release (*Why is it needed?*)	□ At my request □ Other: _____

- This authorization lasts for one year after the date you sign it unless you enter a different date here: _____
- This authorization may be canceled in writing at any time, by providing written notice to the Privacy Officer. A cancellation will not change releases that happen before the cancellation.
- The releasing provider will not restrict your treatment if you choose not to sign this authorization.
- A photocopy or other electronic copy of this authorization will be treated as an original.
- The releasing provider may have received health records from other providers which have been incorporated into your records at the releasing provider. If those records are included in those authorized above, they will be released.
- The releasing provider cannot prevent re-disclosure of your information by the person or organization that receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the releasing provider from any and all liability resulting from a disclosure by the recipient.

Your signature below indicates you have read and understand this form, authorize release of your information as described above and have received a copy of this authorization form signed by you.

Signed by: _____ _____

Signature of Individual or Legal Guardian/Legal Representative Date

Print Name of Individual or Legal Guardian/Legal Representative

Relationship to Individual/Legal Authority

IF RECORDS PICKED UP IN-PERSON **(Must be the patient named above (or his/her Legal Guardian/Legal Representative) or the individual listed as the Receiving Party above)**		
Pickup Confirmation Signature: _____ Date: _____ Printed Name: _____ Type of Identification Provided: _____		
FOR STAFF USE ONLY – Method of Transmittal		
☐ Pickup hard copy ☐ Pickup electronic copy ☐ Secure email ☐ Fax ☐ Mail to address above ☐ The attached Notice Accompanying Disclosure of Records was enclosed with the records released (mandatory)	Date of Transmittal: _____	Staff Name: _____