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Release of Medical Records Request

This authorization must be written, dated, and signed by the patient or by a person authorized to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. Eveningstar Natural health does not offer reimbursements for records received.

Patient Name _____

Address _____

Date of Birth _____ Phone _____

Physician and Clinic _____

Address _____

_____

Phone _____ Fax _____

****** Please release the following information ******

By checking the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information. I also authorize the above physician/clinic/hospital to provide the following via telephone consultation

_____ All medical records necessary for the continuity of care

_____ Labs and diagnostic imaging only

_____ Other _____

Patient signature _____ Date _____

Parent/guardian signature (if applicable) _____ Date _____

****** Confidential Information ******

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information to Eveningstar Natural Health I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

____ HIV/AIDS test results and related information, including high risk behavior documentation.

____ Drug/Alcohol diagnosis, treatment, or referral information.

____ Mental Health information.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.

2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.

3. Inspect a copy of Patient Health Information being used or disclosed under federal law.

4. Refuse to sign this authorization.

5. Receive a copy of this authorization.

6. Restrict what is disclosed with this authorization.

7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____

Signature of Patient or Patient's Authorized Representative Date