AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____ From: CorrectHealth - _____

_____ _____

_____ _____

Patient: _____ Alias: _____ DOB: ____-___-____

Social Security: _____-_____-_____ Date(s) of Service: _____

I hereby authorize the above named provider to release to CorrectHealth the following information:

___ Provider's summary of diagnosis, medications, treatments, prognosis and recent care
___ Admission / Operative / Discharge Summaries
___ Laboratory / Pathology Reports
___ Dental Treatment Records
___ Immunization History
___ Diagnostic Imaging / Special Studies Reports
___ Other Records: _____

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

_____ _____ _____

Patient's Signature *Witness' Signature* *Date*

Supplemental Request for Psychiatric, Substance Abuse, or HIV Information

I hereby authorize and request the custodian of my medical records with _____ to make available for inspection and copy records related to the course of my treatment as a patient of CorrectHealth. This authorization includes an authorization to release the following:

1. *Any and all records of psychiatric consultation and/ or treatment, which are a part of, said medical records which are subject to the confidentiality requirements established by state code or federal regulations.*
2. *Records of alcohol and drug abuse diagnosis and treatments which are subject to state code or federal regulations to Treatment Act of 1972 (Public Law – 92-255), or Section 333 of the Federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (Public law – 91-616).*
3. *Any and all records concerning testing for HIV (human immunodeficiency virus) and / or treatment for HIV or AIDS (acquired immune deficiency syndrome) and any related conditions.*

I understand that this authorization shall constitute a waiver of any and all claims that I might have against _____ or any of its agents, servants or employees as a result of their compliance with this request, and that neither _____ nor any of its agents, servants or employees shall have any responsibility for any acts or omissions concerning said records or their release after the records are made available as I have hereby authorized and requested.

Purpose for which information may be used: Continuity of Care / _____

This authorization is valid until: _____ (date). I understand I am entitled to a copy of this authorization.

Signature _____ _____ _____

Parent or Guardian if Patient is a Minor *Witness Signature* *Date*

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

_____ _____

Signature and Title for CH *Date*