**PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS**

*(medical record number)*____________ (*Date requested)*__________

I: ____________________________________________________________

*(full name of patient)* *(date of birth)*

I authorize ❒ Hillsdale Community Health Center to use/disclose my health information (as outlined below)
❒ Other: ________________________ to use/disclose my health information (as outlined below)

TO: ❒ Receiving Party: ____________________________________ ❒ Hillsdale Community Health Center
____________________________________
____________________________________

**Specific type of information to be disclosed *(include dates of treatment, check all that apply)***

*I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service or mental health records, communications made to a social worker and HIV/AIDs and AIDS related complex information or documentation, if such information exists.*

❒ History/Physical ❒ Discharge Summary ❒ Operative/Path report ❒ Psychotherapy notes
❒ Emergency Department record_____________ ❒ Diagnostic testing (lab, x-ray, cardio)______
❒ Mental health ❒ HIV/HIDS, and AIDs ❒ Drug and/or alcohol treatment
❒ Other __________________________________

**Purpose and need for disclosure**

❒ Continuing care ❒ Insurance billing ❒ Disability ❒ Personal Use ❒ Marketing purposes
❒ Application for employment ❒ Fundraising activities ❒ Enrollment in a Health Plan
❒ Other: _______________________________________

*I understand that I may revoke this authorization at any time by sending a written revocation to Hillsdale Community Health Center except to the extent that Hillsdale Community Health Center has taken action in reliance on the authorization.*

*I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving party and may no longer be protected by federal or state law.*

*I understand that my continued or future treatment by Hillsdale Community Health Center is not conditional upon my providing or signing this authorization unless this authorization is providing data in connection with medical or clinical trial research.*

*I understand that if Hillsdale Community Health Center is the Receiving Party, I have the right to inspect or copy the health information Hillsdale Community Health Center intends to use or disclose, pursuant to this authorization and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.*

*I further understand that correspondence, and records from other health care providers will not be released with this routine request.*

*Please be aware there is a charge to copy and transfer records, unless you are transferring to another physician practice. There is no charge to send directly to another physician. HCHC has a relationship with Smart Corporation to perform this service in accordance with the guidelines of HIPAA. You can expect to receive an invoice from Smart Corporation upon completion of your copy/transfer record request.*

*This authorization is made in accordance with federal and state law and is valid for a period of one year after being executed; however, it may be revoked by me at any time by providing written notice to the above named party. A facsimile or photocopy of this document will be accepted in lieu of the original.*

___________________________________________ ____________________

*Patient Signature or Legal Guardian* *(Date)* *ID Number*

___________________________________________

*(Witnessed by)* *( Date)*