Medical Records Request / Authorization for Disclosure of Health Information

The following form authorizes the medical provider designated below to disclose or discuss specified medical records or information to a designated recipient.

Patient Information

Patient Name: ______________________

Date of Birth: ______________________

Address: ______________________

Telephone Number: ______________________

Releasing Facility Name ______________________

Phone: __________ **Fax:** __________

Authorized Recipient Name ______________________

Recipient Address: ______________________

Recipient Telephone: ______________________

Recipient Fax: ______________________

Recipient Email: ______________________

(Please be aware that Plumas District Hospital is unable to send medical records via email at this time. If you wish to receive your records via email at the time this service becomes available, please include your email address above.)

Health Information Requested (*check all that apply*)

☐ All records

☐ Records dated from ____________ to ____________

☐ Laboratory Results dated from ____________ to ____________

☐ Laboratory results regarding specific test(s) only (*specify*):

____

☐ Radiology records: ☐ Images or films

☐ Reports

☐ Digital/CD, if available.

☐ Radiology results regarding specific test(s) only (*specify*):

____

☐ Records related to a specific injury, treatment, or other purpose (*specify*):

____

Note: records may include information related to mental health, alcohol or drug use, and HIV or AIDS. However, treatment records from mental health and alcohol or drug departments and results of HIV tests will not be disclosed unless specifically requested (*check all that apply*):

☐ Mental health records
☐ Alcohol or drug records
☐ HIV test results

Preferred method of delivery of requested records:

☐ Mail
☐ Pick up
☐ Electronic delivery/Email *(unavailable at this time)*

Preferred format:

☐ Paper copy
☐ CD
☐ Email (*unavailable at this time*)

This authorization is effective for one year from the date of the signature unless a different date is specified here: ______________

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient signature*: ____

Date: ______________

Print name: ____

If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

☐ Parent or guardian of minor patient who could not have consented to health care

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

For Internal Use Only – Medical Records Request

Patient Name: ____

Originating Building

☐ QUINCY BUILDING

☐ NORTH FORK BUILDING

☐ FEATHER RIVER BUILDING (DENTAL)

☐ INDIAN VALLEY MEDICAL CLINIC

☐ HOSPITAL

Request Faxed: ____
(date and employee initials)

Request Completed: ____
(date and employee initials)

Authorization Form scanned in to EHR: ____
(date and employee initials)

Disclosure Management recorded in EHR: ____
(date and employee initials)