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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Patient: _____

Date of Birth: _____ Phone #: _____ Social Security #: _____

☐ **I am requesting the below provider release my information to Homefield Health.**

☐ I authorize Homefield Health to release my information to the below provider.

Provider Name: _____ Facility: _____

Facility Ph: _____ Facility Fax: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED

_____ Any Treatment from _____ (date) to _____ (date)

_____ Entire Medical Record	_____ Mental Health Records	_____ Psychological Testing
_____ Medication List	_____ Lab Reports	_____ X-Ray Reports
_____ Discharge Summary	_____ Immunizations	_____ Operative Report

_____ Other (please specify) _____

PURPOSE OF THE USE AND DISCLOSURE

_____ Further Treatment (Date of Appointment _____)

_____ Personal Records	_____ Referral to Specialist	_____ Disability Determination
_____ Insurance Application/Claims	_____ Workers Comp	_____ Other _____

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected it I do not sign this form. I understand that I may revoke this authorization in writing at any time, except the extent action has already been taken in reliance on it. I understand that this authorization will expire 12 months from the signing date.

A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____

Signature of Patient/Guardian/Representative Date

_____

PRINT Name of Patient/Guardian/Representative

_____

(If not patient, state authority/relationship)