



Medical Records Release Form

Authorization for CHAS Health to Obtain or Disclose My Health Care Information

**Required

Patient Name: Previous Name: Date Records Needed By:
Date of Birth:
**Daytime Phone:

**Please check one:

I request and authorize CHAS to: Release To Obtain From

Name: Address: City: State: Zip Code: Phone: Fax:

**You may use or disclose the following health care information (check all that apply):

- Verbal Release (please specify what can be disclosed):
Dental: Records X-rays
Chart notes
Lab Reports
X-ray/Diagnostic Reports
Medication List
All health care information does not include sensitive information, please see below(includes 2yrs, unless specified)
OB Records
Billing Records
Immunizations
Other:

I understand that my medical record may include information on the diagnosis/treatment related to psychiatric, psychological or mental conditions, drug and or alcohol use or abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), and or HIV status and genetic testing.

I consent for the following information to be disclosed: (initial by any/all that apply):

HIV (AIDS virus) Sexually transmitted diseased
Psychiatric disorder/mental health Drug and/or alcohol use

**Reason for Authorization: At the request of the individual; Other:

**Expiration: Date: OR Event (one time release):

If date is not specified, this request will expire in 90 days from the date of signature.

If the release is for the patient's EMPLOYER or FINANCIAL INSTITUTION for reasons other than payment, this authorization will remain valid for only 90 days. Patient may revoke this authorization at any time prior to expiration by notifying CHAS in writing.

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care information containing drug and alcohol diagnosis and treatment, mental health and sexually transmitted diseases, including HIV/AIDS are privileged and confidential and may only be disclosed by express authroization, except as required by law. I understand that my alochol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to sign this authorization. CHAS may not condition treatment, payment, enrollment or eligibility on the authorization of this release.

**Signature/Legally Responsible Party Relationship to Patient **Date

A minor's signature alone is sufficient to release health care information related to (1) sexually transmitted diseases, including HIV/AIDS (age 14+), (2) alcohol and/or drug abuse (age 13+ (Idaho is 16+)), (3) mental health information (age 13+ (Idaho is 14+)), (4) birth control services (WA only), (5) abortion services (WA only), and (6) prenatal care services (WA only).

Signature of Minor Patient Date