PRISM HEALTH

RELEASE OF INFORMATION

PATIENT INFORMATION			**TODAY'S DATE:**
Last Name:	First Name:		Middle Initial:
Address:			Date of Birth:
City:	State:	Zip:	Phone:

RELEASE INFORMATION FROM:
I hereby authorize the physician/facility listed below to share my individually identifiable health information, which may include protected or privileged information to Prism Health:

Facility or Provider Name:	
Address:	Phone Number:
City: State: ZIP:	Fax Number:

INFORMATION TO BE DISCLOSED
Please check what information you want released (check all that apply):

- ☐ My records for medical treatment from the following time period: _____ to _____
- ☐ Most recent laboratory results
- ☐ Gender Non-Conforming
- ☐ All Medical Records
- ☐ Other records: _____
- ☐ Release is to EXCLUDE the following: _____

PURPOSE

- ☐ Continued care by another provider
- ☐ Insurance Claim
- ☐ Social Security Disability
- ☐ Legal Reasons
- ☐ Personal Use
- ☐ Other : _____

SENSITIVE INFORMATION
All records will be released to the named person or organization listed above. This includes details of mental health treatment, substance abuse treatment, and HIV/AIDS related information. If you do NOT want one of the aforementioned categories released, please fill out the section below.

I do NOT want the following records released:

- ☐ Mental Health Treatment
- ☐ Substance Abuse Treatment
- ☐ HIV/AIDS Related Information

RELEASE AND EXPIRATION OF ROI

Unless you specify otherwise, this Release of Information will expire 12 months from the date it was signed. If you would like this Release of Information to expire sooner than 12 months, please specify the date you would like it to expire: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. This authorization may include disclosure of information relating to mental health treatment, substance abuse treatment, and HIV/AIDS related information unless I dictated otherwise. I understand that this Release of Information will expire 12 months from the date it is signed unless I indicate otherwise. If at any time I change my mind and want to revoke this Release of Information, I must contact Prism Health in writing to make the request. This form is not valid unless it is signed and dated by the patient.

Patient's Printed Name: _____

_____ _____
Patient Signature Date