AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

Patient's Name_____ D.O.B. _____
Daytime Ph #: _____ Cell Ph #: _____

Information to be released:

☐ Discharge Summary ☐ History/Physical ☐ Consultation Report
☐ Lab results ☐ Radiology reports ☐ EKGs
☐ Operative report ☐ Pathology Report ☐ Physician Notes

☐ Other _____

Treatment Dates: from_____ to _____

Information to be disclosed will be used for: Check the appropriate box (s) and include other info where indicated

☐ Continuation of Care ☐ Insurance ☐ Litigation ☐ Personal
☐ Transfer of Care ☐ Other _____

☐ **Release TO Horizon Healthcare**	☐ **Release FROM Horizon Healthcare**
213 NW 10th Street Ste A	**213 NW 10th Street Ste A**
Fairfield, IL 62837	**Fairfield, IL 62837**
Phone: 618 842-4617 Fax: 618 842-4743	**Phone: 618 842-4617 Fax: 618 842-4743**
ATTN:_____	ATTN:_____

Name:_____
Facility:_____
Address:_____ City:_____ State:_____ Zip: _____
Phone:_____ FAX (If known)_____

Paper records will be provided unless electronic records (CD) are requested. ☐

****If information is released TO Horizon Healthcare, please return a copy of this form with the materials requested****

By initialing below, I am releasing the following information under this authorization:

_____ HIV/AIDS or communicable disease information
_____ Mental health information (ex: depression, anxiety, or any behavioral problems)
_____ Drug/alcohol abuse treatment information
_____ Developmental disability treatment information

- I understand that I may revoke this authorization at any time by WRITTEN REQUEST
- I understand that the revocation will not apply to information already released in response to this authorization
- A photocopy or facsimile of this authorization will be treated in the same manner as the original, and the healthcare organization may deny release of protected health information, if 1) release is not a true and accurate authorization initiated by the patient or 2) is dated prior to the treatment dates for which records are being requested.
- I understand that once information is released pursuant to this authorization, Horizon Healthcare cannot prevent the re-disclosure of the information to a third party

I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

This Authorization will expire ONE YEAR following the date of signature except in the case of continuing care.

_____ _____ _____
Patient/Parent/Legal Responsible Party Relationship Date

Identification for pickup is required.

Date Received _____Date Processed_____ Request Completed by_____

☐ Faxed ☐ Mailed ☐ Recorded in PHI Log