# Regional Health Partners

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## Authorizations for Medical Records Release

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

**I hereby authorize the release of my medical records or copies of such and request that**

- ○ Regional Health Partners, LLC
- ○ Other: _____

**Send my records to:**

- ○ Myself
- ○ Regional Health Partners, LLC
- ○ Recipient Name _____
  Phone Number _____ Fax Number _____
  Address _____
  City _____ State _____ Zip Code _____

**Method of Delivery**

- ○ Please mail the records by certified mail. I understand there is a $25 charge for this, in addition to postage expenses. If I do not sign for the certified mail and it is returned to RHP, I must pick up my records during regular business hours. *You will receive your records within 7-10 days.*
- ○ Please fax my records to the number above. I understand there is a $25 charge for this. I understand that by having my records faxed, I risk another person viewing my confidential medical information. If you choose to receive medial records at a company, be aware that some companies use digital fax software, and a copy of the fax is stored in a computer perhaps indefinitely. *Your records will be ready to fax within 3-5 days.*
- ○ I will pick up my records during regular business hours. I understand that there will be a $25 charge for this. *Your records will be ready for pick up within 3-5 days.*

**Medical Records to be Released (Please choose one.):**

- ○ Complete History of Medical Records
- ○ Current Medical Records dated from _____ to _____
- ○ Other: _____

I understand that if the person or agency that receives my information is not a healthcare provider or health plan covered by HIPAA privacy regulations, the information described above may be redisclosed, and is not longer protected by these regulations.

I understand that written notification is necessary to cancel this authorization, and can be addressed to the department listed at the bottom of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that RHP may not condition treatment on my decision to sign this authorization.

**I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).**

_____ _____
Signature of Patient and Parent/Guardian if patient is a minor Date

_____
Print Name of Patient and Parent/Guardian if patient is a minor

**Official Use Only**
**Staff Initials:_____Date:_____**
***Please use Medical Records Release Fax Coversheet when faxing.**

**Notes:_____** **Rev 04/30/13**