BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC

Authorization to Release Protected Health Information

(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
Address: _____ City, State, Zip: _____
Phone: _____
I request that my protected health information from:_____(Practice) be disclosed to:
Facility-Clinician-Person: _____
Address: _____ City, State, Zip: _____
Phone Number: _____ Fax Number: _____
Email address:_____ (**The risk associated with releasing protected health information via unsecure email has been explained to me. I understand those risks and select to proceed with release of my protected health information from, or to, BMRHC) _____ Patient Initials (Required)

I authorize the following protected health information to be released from my medical record(s):
☐ Date(s) of Service: ____/____/_____ through _____/____/_____
☐ Office Note ☐ Test Results (Lab, X-Ray, Pathology) ☐ Billing Records
☐ Other (Immunization Records, Medication Lists) Please specify: _____

I understand that the information in my medical record may include information relating to sexually transmitted disease (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and alcohol or drug abuse. Federal law protects the following information. **If this information applies to you, please indicate if you would like this information released/obtained** (include dates where appropriate):

Alcohol, Drug or Substance Abuse Records ☐ Yes ☐ No Dates: _____
HIV Testing and Results ☐ Yes ☐ No Dates: _____
Mental Health ☐ Yes ☐ No Dates: _____

Purpose for requesting information:

☐ Personal Use ☐ Continued Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Other _____

By signing this authorization form, I understand that:

1. I have a right to withdraw this authorization at any time. Requests to withdraw must be made in writing and presented to Practice. I understand that stopping this release will not apply to information that has already been released.
2. This authorization will expire_____ (insert date or event). If I fail to specify an expiration date or event, this authorization will expire 90 days from the date it was signed.
3. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
4. Once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by the federal privacy laws or regulations.
5. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used or disclosed under this authorization.
6. Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

ACKNOWLEDGEMENT

_____ _____
Patient **OR** parent, guardian, authorized representative signature Date

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FOR OFFICE USE ONLY: □ Verified ID (ex. copy of driver's license, check signature, etc.)
□ Picked Up (who) _____ □ Mailed □ Faxed □ Other_____
Office Personnel: _____ Date: _____

Autorización para divulgar información médica protegida

(POR FAVOR IMPRIMIR)