AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

SUBMITTING YOUR REQUEST

Medical records are protected health information and as required by state and federal law, this information is kept in strict confidence. Protected health information is only released with proper authorization from the patient or the patient's designated representative.

While this process may seem cumbersome, (especially if you have a long-term relationship with your doctor) it is designed to protect your privacy and prevent unauthorized access to your medical information.

The attached form, when completed, will provide any doctor office or healthcare facility all the necessary information to release protected health information to the person or entity you designate on the form.

Please be aware that in many states doctors or facilities do charge a fee to provide you a copy of your medical records. The fee is to defray the costs to copy or reproduce medical records. It takes time, equipment and people to create a copy or reproduction of documents—even from electronic files. With the recent changes in the healthcare laws, regulations and reimbursement schedules doctor offices and facilities are not able to absorb these costs. Please consult with the facility or doctor who has the records regarding any fees. If you are only requesting a few pages, they may waive their normal fees for this service.

One you have completed the form, do not forget to sign it before sending it to a doctor office or healthcare facility.

If you have any questions, please feel free to contact us at info@Arctrieval.com and we would be happy to assist you.

Be Well

Your Arctrieval Team

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FACILITY OR DOCTOR WHO HAS THE RECORDS

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax Number: _____

PERSON MAKING THE REQUEST

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax Number: _____

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

RELEASE HEALTH INFORMATION TO

I authorize the facility or doctor listed above to release protected health information to:

Entity or Person: _____ Contact Name: _____

Address: _____ Telephone: _____

City, State, Zip: _____ Fax: _____

PROTECTED HEALTH INFORMATION TO BE RELEASED

- ☐ Pertinent Information for Continuing Care
- ☐ Billing Statements
- ☐ Consultation Reports
- ☐ Discharge Instructions
- ☐ EKG / ECHO
- ☐ ER Record
- ☐ History & Physical Exams
- ☐ Laboratory Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Progress Notes
- ☐ Radiology & Other Imaging Diagnostic Reports
- ☐ Images (X-rays, MRI, CT, etc…)
- ☐ All Records
- ☐ Other: _____

I specifically authorize the release of the following information (check as appropriate):

- ☐ Alcohol or drug treatment information
- ☐ STD/ HIV test results
- ☐ Mental health treatment information (other than psychotherapy notes)

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REQUESTED SERVICE DATES

☐ Most Recent Visit ☐ Last Six Months ☐ Date(s): _____

PURPOSE OF RELEASE

☐ Continuing Care ☐ Personal Copy ☐ Other: _____

INFORMATION DELIVERY

☐ Faxed to number listed on form ☐ U.S. Mail

☐ Other: _____ ☐ Password protected PDF via email

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such redisclosure is in some cases not prohibited by state law and may no longer be protected by federal confidentiality law (HIPAA).

I may revoke this authorization at any time, but I must do so in writing and submit it to the facility or doctor holding the records as listed on this form. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

EXPIRATION

Unless, otherwise revoked, this Authorization expires _____ (insert date). If no date is indicated, it will expire upon its completion or 12 Months from date of signature, whichever comes first.

SIGNATURE

Signature: _____ Date: _____

Printed Name: _____

Relationship: _____ (If not patient)

Telephone: _____ (If not patient)

Email Address _____ (If not patient)