capitalhealth
Minds Advancing Medicine

Authorization for Patient Access/Release of Health Information
Capital Health Medical Group

Patient Name:	Medical Record #:
Date of Birth:	Phone #:
Home Address: City: State: Zip:	

1. Type of Request: I hereby request the following:
- ☐ Access to review my original medical record
- ☐ Release/Disclosure of my health information, as requested below
- ☐ Request my medical records from another facility

Name of Physician Practice: _____

2. Description of Information To Be Released: *(Check ALL that apply)*

☐ Abstract* (defined below)	☐ Entire Medical Record	☐ History and Physical	☐ Operative Reports
☐ Immunization Record	☐ ER Record	☐ Progress Notes	☐ X-ray Reports
☐ Outpatient Records	☐ Consultation Reports	☐ EKG/EEG	☐ Discharge Summary
☐ Treatment Record	☐ Labs	☐ Other (*specify):*	

Date of Service _____

*(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)*

I understand that the specific information to be released may include reference to alcohol abuse, drug abuse, AIDS/HIV infection, sexually transmitted diseases, tuberculosis, genetic information, and/or psychiatric conditions and the treatment of any of these disorders. If this information is documented in my medical record, I agree to the release of it.

3. Disclose/Send Information To:
- ☐ Myself *(the patient or authorized representative)*
- ☐ To Organization/Individual below:

Organization:	Individual Name:	Phone #:

Street Address: City:	State:	Zip Code:	☐ Please mail ☐ Please fax: _____ ☐ Please prepare for pick up

4. Purpose of Release: I authorize Capital Health to release my health information for the following specific purpose:

5. Term/Expiration: I understand that by law, I do not have to release this information and I choose to do so voluntarily. I may cancel this authorization by providing a written revocation to Capital Health, Health Information Management Department at either campus. This authorization will automatically expire twelve (12) months from the date listed below. *I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.*

6. Fees:
Capital Health charges a reasonable fee for retrieval of medical records and preparation of photocopies for purposes other than patient care.

Signature of Patient or Patient's Representative Date

Relationship to Patient Witness Signature