AUTHORIZATION FORM FOR RELEASE OF PERSONAL HEALTH INFORMATION

Goodwin Community Health

Patient Name: ____ **DOB**: ____________________

I authorize **Goodwin Community Health** ("**GCH**") to the use or disclosure of the above-named individual's personal health information as described below.

Release my Protected Health Information from:

Name: ____________________________________

Address: __________________________________

City, State, Zip: ____________________________

Phone #: __________________________________

Fax #: ____________________________________

Office **receiving** my Protected Health Information:

Name: ___________________________________

Address: __________________________________

City, State, Zip: ____________________________

Phone #: __________________________________

Fax #: ____________________________________

Is the purpose of this release to transfer your care? ☐ **Yes** ☐ **No**

If yes, please check below the care you are transferring to another provider:

☐ Medical ☐ Dental ☐ Behavioral Health ☐ All

If no, purpose of release: ____

Please initial the type and amount of information to be used or disclosed is as follows:

______ Medical diagnostic, testing, and treatment information
______ Dental diagnostic, testing and treatment information
______ Dental x-rays; date x-rays taken: ____________________
______ Immunization record
______ Current prenatal records, copies of all lab tests (including HIV results) and/or scans
______ Summary of labor and delivery notes; date of delivery: ________________________
______ Pregnancy Test Results
______ Sexually Transmitted Diseases
______ HIV/AIDS
______ Psychiatric/psychological evaluation(s), reports, assessments, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records and behavioral observations.
* **Provider Acknowledgement:** ______________________________________ **Date:** _______________
______ Other: ____

Methods of Disclosure Authorized: Faxed, written, phone conversation, in-person and/or secure e-mail

- I understand that I have the right to revoke this authorization in writing, at any time by presenting written notification to GCH. Revocation will be effective as of the date received.
- I understand that a revocation will not be effective to the extent that GCH has taken action in reliance on the authorization prior to the revocation date, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my clinician generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
- I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by federal privacy regulations.
- I understand that I have the right to: 1.Inspect or copy the protected heath information to be used or disclosed as permitted under Federal law; 2. Refuse to sign this authorization.
- Unless otherwise revoked, I understand this authorization expires on the earlier of one year of date signed or ______________________________.(If left blank, the authorization will expire one year from the date signed).
- Unless otherwise noted only the past two years of electronic records within will be sent

Signature of Patient and/or Legal Representative: ______________________________ **Date:** ___________

For office use only: Witness: ____ Date: ______________
Sent by: ____ Date: ______________