5-Hole 1/4 1 3/8 c-to-c

Patient's Full Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Medical Record No:** _____

RELEASE OF GENERAL HEALTH RECORDS

I AUTHORIZE PRESBYTERIAN HEALTH PLAN, INC. OR PRESBYTERIAN INSURANCE COMPANY, INC. ("PRESBYTERIAN") TO USE OR RELEASE (DISCLOSE) THE FOLLOWING HEALTH RECORDS OF THE ABOVE NAMED MEMBER ("MEMBER").

☐ Billing Records ☐ Case Management Records ☐ All Health Records
☐ Other (Please specify)_____

From (circle one): PHP PIC

For date(s) of service from:_____to_____

To (Name):_____

Address:_____ City:_____

State:_____ Zipcode:_____ Telephone Number:_____ Facsimile (FAX) Number:_____

Records released for the following purpose(s): ☐ Pick Up ☐ Mail Out

☐ At the request of the Individual
☐ To determine eligibility for enrollment in Presbyterian's health plan(s) **(If checked authorization does NOT include psychotherapy notes)**
☐ For Marketing (specify campaign):_____
☐ If checked, Presbyterian will receive direct or indirect payment from a third party as a result of this activity.
☐ Other (Describe each purpose of the requested use or disclosure)

_____

IN ADDITION TO RELEASE OF THE GENERAL HEALTH RECORDS INDICATED ABOVE, BY INITIALING BELOW I ALSO AUTHORIZE THE RELEASE OF HEALTH RECORDS PERTAINING TO THE FOLLOWING CONDITIONS.

(Initial <u>ONLY</u> those records to be released):

_____ Health Records Related to Drug / Alcohol / Substance Abuse

_____ Health Records Related to Sexually Transmitted Diseases

_____ Health Records Related to Human Immune Deficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS)

_____ Health Records Related to Emotional / Mental Health / Developmental Disabilities / Psychiatric Conditions **(Excludes Psychotherapy Notes. This authorization does not authorize release of Psychotherapy Notes. To release Psychotherapy Notes, a separate authorization is required.)**

EXPIRATION: I understand that I may cancel this authorization at any time by sending Presbyterian my notice of cancellation in writing. I understand that Presbyterian may have already used or released records according to this authorization prior to receiving my notice of cancellation. I understand that if this authorization is cancelled, an insurer may still have the legal right to contest a claim or the insurance policy. The insurer's right only applies if this authorization is requested as a condition of obtaining insurance coverage.

UNLESS CANCELLED, THIS AUTHORIZATION EXPIRES (either Event <u>OR</u> Date is required):

☐ In 6 months ☐ When Event occurs (specify):_____
OR on Date:_____

I UNDERSTAND THAT THIS AUTHORIZATION TO RELEASE HEALTH RECORDS IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. I understand signing this authorization may be required as a condition of my enrollment in a Presbyterian health plan if Presbyterian has requested this authorization prior to enrollment in order to determine eligibility or for its underwriting or risk rating determinations. If this authorization is a condition of enrollment in a health plan it does NOT include permission to release psychotherapy notes.

I have read and understand this authorization form including statements that appear on the reverse side of this page. I am the Member or I am legally authorized as the Member's representative to execute this authorization and accept these terms.

_____ _____ _____
Patient or Authorized Representative/Relationship to Patient Date Time
(Relationship to Member required if signed by Representative)

_____
Print Name if Other than Member

2229 (Rev. 8/06)

Copy 1 - Chart Copy 2 - Patient

PRESBYTERIAN

AUTHORIZATION FOR USE AND RELEASE OF HEALTH RECORDS

5-Hole 1/4 1 3/8 c-to-c

RIGHT TO REVIEW: By law, you have a right to see and obtain a copy of the information to be disclosed under this authorization.

FEES: We charge a fee for providing a copy, summary or explanation of the information you request. Before we provide the requested information, we will tell you how much it will cost. You may change your request to avoid or reduce the fee.

DENIAL OF REQUEST: We may deny your request to release your health records only for certain reasons. If your request is denied, you may request a review of this decision as described in Presbyterian's *Notice of Privacy Practices.*

REDISCLOSURE OF INFORMATION: I understand that information released under this authorization could potentially be redisclosed by the receiver of the information. If information is redisclosed by the receiver, the information may no longer be protected under federal privacy law. I understand that Presbyterian cannot prevent the person who receives this information from releasing it to others.

PHYSICIAN RECORDS: I understand that physicians (such as radiologists, anesthesiologists and pathologists) provide services in Presbyterian facilities but may not be employees or agents of Presbyterian. These physicians may maintain additional health records about the Patient (such as billing records). To release information contained in those records the Patient must contact the physician.

CERTIFICATIONS: I certify that prior to signing this authorization all blanks or statements requiring completion by me were filled in and all items that do not apply were left blank. I release Presbyterian Healthcare Services its officers, directors, employees and agents and the physicians who provided Member's healthcare services from any and all liability and claims of any nature that may arise from the release of information requested under this authorization.

A copy of this authorization that contains my signature shall be considered as effective and as valid as the original and shall be honored by those to whom it is provided.

5-Hole 1/4 1 3/8 c-to-c

Patient's Full Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Medical Record No:** _____

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UNLESS CANCELLED, THIS AUTHORIZATION EXPIRES (either Event OR Date is required):

☐ In 6 months ☐ When Event occurs (specify): _____
OR on Date: _____

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2229 (Rev. 8/06)

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5-Hole 1/4 1 3/8 c-to-c

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