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Patient's Full Name:

Social Security Number: _____

Medical Record No: _____

Date of Birth: _____

🖄 PRESBYTERIAN

AUTHORIZATION FOR USE AND

RELEASE OF HEALTH RECORDS

RELEASE OF GENERAL HE	ALTH 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					
From (circle one): PHP PIC					
For date(s) of service from:to_tdeveedeedeedeedeedeedeedeedeedeedeedeede					
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):					
IN ADDITION TO RELEASE OF THE GENERAL HEALTH RECORD AUTHORIZE THE RELEASE OF HEALTH RECORDS PERTAINING (Initial <u>ONLY</u> those records to be released):		W I ALSO			
Health Records Related to Drug / Alcohol / Substance	Abuse				
Health Records Related to Sexually Transmitted Disea	Ses				
Health Records Related to Human Immune Deficiency (AIDS)	Virus (HIV) / Acquired Immune Deficiency Syn	drome			
Health Records Related to Emotional / Mental Health / (Excludes Psychotherapy Notes. This authorization To release Psychotherapy Notes, a separate author	does not authorize release of Psychotherap				
EXPIRATION: I understand that I may cancel this authorization at a in writing. I understand that Presbyterian may have already used o receiving my notice of cancellation. I understand that if this authoriz to contest a claim or the insurance policy. The insurer's right only a obtaining insurance coverage.	r released records according to this authorizat tation is cancelled, an insurer may still have the applies if this authorization is requested as a c	tion prior to e legal right			
UNLESS CANCELLED, THIS AUTHORIZATION EXPIRES (either E					
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)

Copy 1 - Chart Copy 2 - Patient



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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.

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Patient's Full Name:

Social Security Number: _____

Medical Record No: _____

Date of Birth: _____

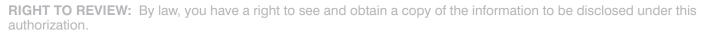
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For date(s) of service from:to_to					
To (Name):					
Address: City:					
State: Zipcode: Telephone Number:	Facsimile (FAX) Number:				
Records released for the following purpose(s): Pick Up Mail Out At the request of the Individual To determine eligibility 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 IN AUTHORIZE THE RELEASE OF HEALTH RECORDS PERTAINING TO T (Initial <u>ONLY</u> those records to be released):		 ว			
Health Records Related to Drug / Alcohol / Substance Abus	e				
	-				
Health Records Related to Sexually Transmitted Diseases					
Health Records Related to Human Immune Deficiency Virus (AIDS)	; (HIV) / Acquired Immune Deficiency Syndrome				
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					
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.					
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Copy 1 - Chart Copy 2 - Patient



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

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