AUTHORIZATION FOR RELEASE AND EXAMINATION OF MEDICAL RECORDS (PHI)

PATIENT NAME:_____ DOB:_____

I hereby authorize and request that you release medical records and information from:

HVCH Rural Health Clinic
Provider: _____
1383 W. Hunter St
Logan, OH 43138
Phone: 740-385-0202
Fax: 740-380-2734

The above listed patient authorizes **HVCH Rural Health Clinic** to make records disclosure to the following:

FACILITY/PHYSICIAN NAME:_____

FACILITY/PHYSICIAN ADDRESS:_____

FACILITY/PHYSICIAN PHONE:_____

FACILITY/PHYSICIAN FAX:_____

I hereby authorize **HVCH RURAL HEALTH CLINIC** to furnish a complete copy of medical records, medical information (PHI) and related data for the above identified person, including:

_____.

I am aware that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I am aware that I can revoke this release at any time prior to the records being released to the above named entity and that this release is valid for a period of 90 days unless otherwise specified.

I am also aware that I may be charged a fee to process this medical record (fee schedule guidelines available upon request).

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**

_____ _____

Signature of Witness **Date**