CHIEFLAND MEDICAL CENTER
Caring for the health of your family

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

Name: _____ Date of Birth: _____ SS#_____

Address: _____ Phone#_____

I authorize:

Office/Doctor Name: _____

Address: _____

Phone #: _____ Fax #: _____

TO RELEASE THE FOLLOWING PROTECTED HEALTH CARE INFORMATION: **WE CAN NOT ACCEPT A DISK**

- o Entire Medical Chart
- o Demographic Information
- o Specific Office Items: _____
- o Labs: _____
- o Other: _____

Send to:

Office/Doctor Name: _____

Address: _____

Phone #: _____ Fax #: _____

This information is to be used for:

- o Transfer of Care
- o Continuation of Medical Care
- o Personal Use

I also understand that I have the right to revoke this authorization any time through written notice and that the written notice must include (1) the patient's name, address and patient number if applicable, (2) the effective date of this authorization and names of those authorized by this form to receive the information, (3) a statement that the patient wants to revoke this authorization and the date revocation is signed and signature of the patient or legal guardian. This authorization will expire six months from the date signed unless otherwise stated. I understand and accept the terms of this authorization.

Signature: _____ Date: _____

Relationship to Patient: _____

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