# Authorization for Release of Medical Records

**Patient Name:** ______________________________________________ **DOB:** ______________
Last First Middle

**Address:** ____________________________________________________________________
Street City State Zip

**Telephone:** ______________________________ **Last 4 Numbers of SSN:** ____________________

**Release Information FROM:**

________________________________________
Facility / Practice / Company

________________________________________
Address

________________________________________
Contact / Telephone / Other Pertinent Information

**Release Information TO:**

________________________________________
Facility / Practice / Person / Company

________________________________________
Address

________________________________________
Contact / Telephone / Other Pertinent Information

**Purpose of Release:** ☐ Patient Request ☐ Insurance ☐ Disability ☐ Worker's Compensation
☐ Legal Process ☐ Other: ___________________________________

**Treatment Dates For Record Release (must be completed): From:** ______________ **To:** ______________

**Check All That Apply:**

☐ Entire Record *Excluding Psychotherapy Notes*
☐ Psychotherapy Records
☐ Consultation Reports
☐ Medications
☐ Office Visits & Physical Exams
☐ Drug and Alcohol Abuse Treatment
☐ Diagnostic Tests & Radiology Reports
☐ Billing & Financial Information

**Format (Charges May Apply):** ☐ Paper Copy ☐ Electronic Copy ☐ CD ☐ Other: ____________________

**Delivery Method:** ☐ U.S. Mail ☐ On-Site Pick-Up ☐ Facsimile ☐ MyChart ☐ Other: __________________

I understand that:

- I can cancel this permission at any time. I must cancel in writing and notify the releasing and receiving parties listed above. Any cancellation will apply ONLY to information not yet released.
- This is a full release, including information related to, genetic information, HIV/AIDS, and other sexually transmitted diseases, **unless limited by the above selections.** (in compliance with HIPAA 42 CFR, Part 2, CFR 45, Part 164 of the Federal Register)
- Information that is disclosed under this authorization may be re-disclosed by the person to which it is given. The privacy of this information may not be protected under the Federal Privacy Rule.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- A fee may be charged for providing the protected health information.

**This permission expires 90 days after the date of my signature, unless another date is written here:** __________

______________________________ ______________________________ ______________
Print Name (Patient/Legal Guardian/POA) Signature Date

______________________________ ______________________________ ______________
**PSYCHOTHERAPY Release Age 12-18 years Print Name** **Signature** **Date**

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**<u>ID Verified</u>** ☐ **By Heartland Employee:** ______________________________ **Title:** ____________________

**Date of Release:** ______ **Heartland Employee:** ______________________ **via:** ☐ **mail** ☐ **fax** ☐ **Other:** __________

Reviewed: 11.2017, 7/2026