Auburn Primary Care

AUTHORIZATION TO OBTAIN/RELEASE HEALTH INFORMATION

Patient Identifiers

Patient Name: _____ Date-of-Birth: _____

A. Select one of the options below

□ **Release** information from Auburn Primary Care to Outside Facility/Person/Clinic **(APC → Outside)**

□ **Obtain** information from Outside Facility/Person/Clinic to Auburn Primary Care **(Outside → APC)**

B. Select the purpose of Release/Obtain request from the options below

□ New Patient Request / Coordination of Care □ Legal □ Continuing Care (Provider/Facility) □ Personal Copy

C. Complete the Outside Facility/Person/Clinic Information

Person/Organization	Phone Number	Mailing Address
	Fax Number	

Information Type(s)

□ Clinic Notes – Most recent three (3) complete office visits

- or -

Date Range of Records Request ___/___/___ **to** ___/___/___

□ Clinic Notes □ Lab Reports □ Radiology Reports □ Other: _____

Acknowledgment of Authorization, Revocation, Information, & Expiration

I understand that this authorization is voluntary. I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by Federal Privacy Rules Act.

I understand that I may revoke this authorization at any time by notifying Auburn Primary Care in writing, and it will not have any effect on uses or disclosures prior to the receipt of the revocation.

I understand 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 understand that this authorization will expire 90 days from the date of signature.

By signing this page, I acknowledge that I have read and agree to the terms on this form.

Signature (Patient or Patient's Authorized Representative):	**Print Name**	**Date**
Provide relationship to patient and description of authority (if applicable):	Signature Witnessed By (Auburn Primary Care Representative):	

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