Navicent Health Form

Z26167 Authorization for Release Medical Information

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Telephone: ( ) _____ Email Address: _____

By providing your email address you acknowledge and accept the risks outlined in the Guidelines for E-mail with Patients, posted on Navicenthealth.org.

Release Information From:	**Release Information To:**
_____ (List applicable Facility(s) and/or Practice(s))	_____ (Name of facility, person, company) (Relationship)
_____	_____ (Street Address or PO Box, City, State, Zip Code)
_____ (Phone number) (Fax number)	_____ (Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal rep ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐ Other _____

Fill in dates of treatment for records to be released:
Treatment dates: From _____ To _____

Facility (check all that may apply):	**Office/Clinic/Home Care (check all that may apply):**
☐ Facility Summary – includes items in bold	☐ Office/Clinical Summary – includes items in bold
☐ **Discharge Summary** ☐ **Emergency Record**	☐ **Office/Home Visits** ☐ **Physical Exam**
☐ **History and Physical** ☐ **Cardiac Reports/EKG**	☐ **Laboratory Reports** ☐ **Radiology Reports**
☐ **Consultation reports** ☐ Assessment	☐ Therapy Notes ☐ Immunization Records
☐ **Operative Reports** ☐ **Laboratory reports**	☐ Other _____
☐ **Pathology Reports** ☐ **Radiology/X-Ray Reports**	
☐ Other _____	☐ Entire Record
☐ Entire record ☐ Itemized Bill	☐ Itemized Bill

FORMAT:	**DELIVERY METHOD:**
☐ CD (charges may apply)	☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Email Address noted above, where permitted	☐ Overnight/Express Mail Service, where permitted
☐ Paper copy (charges may apply)	☐ Secure email
☐ Other _____	☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. Records protected by 42 CFR Part 2 may not be redisclosed without my additional consent.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **Navicent Health will not share or use my health information without my permission other than by ways listed in the Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at Navicenthealth.org.**
- **I have a right to a copy of this Authorization.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ Print Name: _____ Date: _____ Time: _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written proof MAY be requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other: _____**

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: _____ Print Name: _____ Date: _____ Time: _____

Date of release: _____ via ☐ Mail ☐ Fax ☐ Other _____ ☐ ID Verified ☐ DL/Other ID _____
Navicent Health Teammate Name & Department: _____ Date: _____ # of Pages _____