Carondelet Medical Group. Be well.

UNABLE TO PROCESS IF FORM IS INCOMPLETE

PLEASE PRINT

Authorization to Use or Disclose Healthcare Information

_____
Patient Name

_____
Date of Birth

_____
Phone #

CMG Provider Name:

_____

☐ **MAIL RECORDS TO:**

Name _____

Address _____

City _____ St _____ Zip _____

_____
Telephone Fax

☐ **EMAIL** RECORDS TO:

_____
Print email address for record delivery

☐ **PICK UP RECORDS** at this office

I authorize records to be sent from: _____

_____
Address City State Zip Phone # Fax #

The purpose or reason for requesting the information: _____

To disclose the following information, **check** and **initial** all options that apply:

Check Initial

- ❑ __Treatment records, including progress notes, lab and test results, history & physical reports, procedure reports, and consult reports
- ❑ __Include outside records (this box must be checked to release records from non-CMG providers)
- ❑ __Other specified information, photos or digital images

_____

- ❑ __Information related to treatment for HIV or AIDS *
- ❑ __Information related to treatment for mental health-related issues*
- ❑ __Information related to treatment for substance abuse*

Dates of service to be released: From: _____ To: _____

_____
Signature Date Relationship to Patient if not self

I understand that if the organization authorized to receive the health information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. CMG, its employees, directors and medical staff members are released from any legal liability for disclosure of my protected health information in the extent authorized by this form. I understand that CMG will not condition treatment or payment on obtaining this authorization, except where federal law allows such condition.

Fees for copies of records for personal use are listed below:
For up to two (2) years of records, no charge (limit of one free copy). For records from three (3) years ago, or longer, there will be a fee of $0.50 per page plus postage fees. Additional handling fees may apply. Your request will be processed as quickly as possible and records will be sent via regular USPS unless otherwise requested.

This authorization is valid for only 90 days from the signature date. It may be revoked at any time, except to the extent that action has been taken on it.