SHORELINE
RECORDS MANAGEMENT

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date: _____

Date of Birth: _____

I request and authorize Shoreline Records Management to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize this information to be faxed (when applicable) ◯ Yes ◯ No Client Initials: _____

This request and authorization applies to (check below):

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other: _____

Indicate purpose: At individual's request/other: _____

Authorization re: sensitive information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, such information about me will be released if it exists.

☐ HIV/AIDS	☐ Genetic Information	☐ Treatment for alcohol and/or drug abuse
☐ Mental Health	☐ Psychotherapy Notes	☐ Sexually Transmitted Diseases

Without my express revocation, I understand that this authorization will expire in one (1) year from the date signed unless indicated below:

- ☐ Under the following condition(s):_____
- ☐ Upon satisfaction of the need for disclosure
- ☐ On_____(*enter a future date other than date signed by patient not to exceed 1 year)*

I understand that once my medical records leave Shoreline Records Management, there is a potential for redisclosure by the recipient if they are no longer protected by the Privacy Rule.

I may revoke this authorization in writing but any previously disclosed information would not be subject to such revocation. I may inspect or copy the information to be used or disclosed and may refuse to sign the authorization.

Patient Signature: _____ Date Signed: _____

Personal Representative Signature: _____ Authority: _____

Date Signed: _____