

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete this form to authorize Cedar Point Health (CPH) to request your personal health information on your behalf. You may revoke this authorization in writing or by contacting medical records at CPH. Once health information is disclosed, the organization that receives it may re-disclose it. Privacy laws may no longer protect it

PATIENT INFORMATION:	Patient Name: _____ Date of Birth: _____ Phone Number: _____										
AUTHORIZATION TO:	<input type="checkbox"/> Send Information <input type="checkbox"/> Request Information										
INFORMATION MAY BE RELEASED FROM:	Organization: _____ Address: _____ Phone Number: _____ Fax Number: _____										
INFORMATION MAY BE RELEASED TO:	Organization: _____ Address: _____ Phone Number: _____ Fax Number: _____										
INFORMATION TO BE RELEASED:	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> All health information</td> <td><input type="checkbox"/> Radiology</td> </tr> <tr> <td><input type="checkbox"/> Office Notes</td> <td><input type="checkbox"/> Labs</td> </tr> <tr> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Mental health</td> </tr> <tr> <td><input type="checkbox"/> Immunization Records</td> <td><input type="checkbox"/> Mental health substance use/abuse information _____ initial</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> All health information	<input type="checkbox"/> Radiology	<input type="checkbox"/> Office Notes	<input type="checkbox"/> Labs	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Mental health	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Mental health substance use/abuse information _____ initial		<input type="checkbox"/> Other: _____
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	<input type="checkbox"/> Other: _____										
	Optional <input type="checkbox"/> Health information between the following dates: _____ to _____ <input type="checkbox"/> Exclude:										
AUTHORIZATION ENDS:	<input type="checkbox"/> On (date): _____ <input type="checkbox"/> When the following occurs: _____ *If no date provided, authorization ends one year from signing.										
PURPOSE:	Transfer to New Provider and/or Continuity of Care										

 PATIENT NAME (PRINT)

 SIGNATURE

 DATE

 PERSON SIGNING ON BEHALF OF PATIENT

 RELATIONSHIP TO PATIENT