Allen Parish
Community Healthcare
A better you begins with us.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone: _____

Requesting Records **FROM:**	Facility Name:			
	Address:			
	City:	State:	Zip:	Telephone:
Releasing Records **TO:**	Facility/Person Name:			
	Address:			
	City:	State:	Zip:	Telephone:

Purpose of and need for this disclosure:

- ☐ Continuation of care with another physician
- ☐ Transfer of care to another physician
- ☐ Change in Insurance or insurance inquiry
- ☐ Moving from area
- ☐ Other _____
- ☐ Application for Medicare, Life Insurance, Long Term Care Insurance
- ☐ Attorney office requesting records for Litigation
- ☐ Social Security Administration (disability)
- ☐ Patient's personal Use

Dates of Service Requested: _____ / _____ / _____ TO _____ / _____ / _____

Specific Type of Information to be Released:

- ☐Complete Medical Record
- ☐Discharge Summary
- ☐History and Physical
- ☐Operative Reports
- ☐Progress Notes
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Hospital Billing Statements
- ☐ Other_____

_____ _____

Print Name **Relationship to patient (If Applicable)**

_____ _____

Patient Or Authorized Representative Signature **Date**

State and Federal law protect the following information:

- Alcohol, Drug, or Substance Abuse Records
- HIV Testing and Results
- Psychotherapy notes
- Mental Health Records
- Genetic Records

If this information applies to you, please indicate if you would like this information released/obtained.

Dates of Service Requested: _____ / _____ / _____ TO _____ / _____ / _____

Specific Type of Information to be Released:

☐Alcohol, Drug, or Substance Abuse Records ☐ HIV Testing Results
☐Psychotherapy Notes ☐ Mental Health Records
☐Genetic Records ☐ Other_____

Disclosure Format (Paper is default if not marked.):

☐US Mail ☐ Fax
☐E-Mail ☐ USB Drive (Thumb drive)
☐Other Electronic Format: _____ ☐ Other_____

_____ _____

Print Name **Relationship to patient (If Applicable)**

_____ _____

Patient Or Authorized Representative Signature **Date**

Important Information About Authorization

Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the address listed below. Revocation will not apply to information that has already been disclosed in response to this authorization.

I understand that this authorization will expire on _____ / _____ / _____. If left blank, this authorization expires 1 year from date of signature.

We may need your authorization to use, disclose or obtain your health information for some of our services.

When required by law or policy, APCH may only obtain, use, and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, APCH will use and disclose your health information as you have authorized on the signed authorization form.

YOUR RIGHT TO FILE A PRIVACY COMPLAINT

You may contact the privacy officer listed below if you want to file a complaint or to report a problem about how APCH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. APCH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful.

Your Privacy officer contact is:

Allen Parish Community Healthcare

HIM Director

108 6th Ave

Kinder, LA 70648

Email: medicalrecords@allenhealth.net

HIM Department Phone: 337-738-9405