MaxHealth

Authorization to Release Healthcare Information

Patient Name: _____ Birth Date: _____

Previous Name: _____ Social Security: ###-##-_____

I request and authorize my healthcare information to be:

Release to:

MaxHealth

Fax to: 866-554-1914

Release from:

_____

_____

INFORMATION TO BE PROVIDED (check one or more):

☐ All Medical Records/Information
☐ Abstract
☐ Billing records
☐ Outpatient Record
☐ Diagnostic Test/Results
☐ History & Physical
☐ Discharge Summary
☐ Other: _____

Do not include:
_____

Unless indicated above, I acknowledge that this request specifically includes medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, AIDS related information, and genetic information if in the possession of MaxHealth ("MaxHealth").

Please include date(s) of service from: _____ to _____ (records will be provided for all service dates if left blank)

FORMAT

I request that the copy be provided (where possible/available):

☐ On paper ☐ In an electronic format ☐ Discuss my medical information only ☐ Other: _____

If requesting an unencrypted format, by signing below you acknowledge that you understand the inherent risks involved with sending and receiving information in an unencrypted, unsecured, format (such as regular email or unencrypted disc). Such risks include misdirected messages, email intrusion, interception, or views by unauthorized parties. I understand there may be a fee for a copy of my health information. All fees will be in compliance with applicable law.

Patient Signature:_____ Date:_____

THIS AUTHORIZATION EXPIRES WHEN THE PATIENT IS
NO LONGER UNDER THE CARE OF THE FACILITY REFERENCED ABOVE