BARTZ-ALTADONNA
Community Health Center

Records should be faxed to BACHC at (866) 572-7851

Authorization to Release or Request Health Information

PATIENT INFORMATION *		
Patient Name:		Date of Birth:
Address:		
Phone Number:	Email:	Date of Request:

INFORMATION TO RELEASE/REQUEST FROM

I Authorize BACHC to release/request medical records

☐ Release to: _____

☐ Request From: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Purpose of this request: ☐ **Transfer of care** ☐ **Insurance Personnel** ☐ **School** ☐ **Legal** ☐ **Other:**_____

Request Complete Medical Record or Preventative Care Records: By initialing here, you authorize BACHC to retrieve your complete medical record history or preventive care records. This will assist in understanding and optimizing your care.

_____ * **Initial**

☐Preventative Care Records ☐Complete Medical Record

Specific Information to Release/Request:

☐History and Physical Report ☐EKG/ECHO ☐Pathology Report ☐Laboratory Report ☐Radiology Report
☐Operative Report ☐Discharge Summary ☐Consultation Report ☐Emergency Report ☐Billing Record
☐ Entire Record ☐Treatment ☐Diagnosis ☐Assessment/Evaluation

☐Other: _____ Treatment Dates: _____to _____

Records may include information related to alcohol or drug use and HIV or AIDS. However, treatment records from drug and alcohol facilities or results of HIV test will not be disclosed unless specifically requested. Mental health and behavioral health information if marked will require a seperate authorization.

☐ HIV Information ☐Drug/Alcohol Treatment Information ☐Mental/Behavioral Health Information

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Receive a Copy of Authorization - I understand that if I agree to sign this Authorization, which I am not required to do, I can request a copy of the signed form.**
- **Right to Revoke Authorization - I understand that I have the right to revoke this Authorization at any time by notifying BACHC in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to address listed within the Revocation.**

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YOU ARE REQUIRED TO READ AND SIGN BELOW. I UNDERSTAND THAT:

- **I understand that the health center will not deny me treatment because I refuse to sign this Authorization.**
- **I understand that I may revoke this Authorization at any time by signing below the "revocation of authorization" or inform BACHC in writing, unless the health center has already taken action based on this Authorization, or unless this Authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy.**
- **I understand that this Authorization is valid for a one-year period from the date of my signature below, but that the information disclosed based on this Authorization may be re-disclosed by the entity or the person who receives the information. Once disclosed, it is possible that the information will no longer be protected under Federal or State privacy laws.**
- **I may inspect or copy the medical information that is being released, used and/or shared pursuant to this Authorization Form.**
- **The use or disclosure of information obtained or released pursuant to this Authorization may result in direct or indirect payment to BACHC from a third-party, including copying fees.**
- **I understand that the use or disclosure of HIV-related and drug/alcohol treatment is highly sensitive and requires the specific authorization I have provided by marking the boxes above. A separate authorization form would need to be completed if I were to request to see my own Mental/Behavioral Health Information.**
- **I understand that if the records or information being released involve treatment for alcohol or substance addiction, my records are also protected by Federal law and regulations relating to "confidentiality of alcohol or drug abuse patient records,"(42 C.F.R. Part 2, 42 U.S.C. § 290dd-2).**
- **I understand that there may be a charge for the requested records.**

Signature: *	**Printed Name:** *(If other than patient, print relationship)* *	**Date:** *

BACHC understands the importance of your request and strives to process your request as soon as possible in the order in which your request was received. Please let us know if the requested information is needed by a specific date and every effort will be made to meet your needs. BACHC complies with HIPAA regulations which require processing of requests for medical information within 30 business days of request.

NOTE TO INDIVIDUAL OR ENTITY AUTHORIZED TO RECEIVE ALCOHOL OR SUBSTANCE ABUSE ADDICTION RECORDS Pursuant to This Notice: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2) relating to the confidentiality of alcohol and substance abuse records. Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client of BACHC.

REVOCATION OF AUTHORIZATION

Name of Patient:	**Signature of Patient/ Legal Representative:**	**Date:**

Contact person:	**Facility Name:**	**Phone Number:**
Address:		

If signed by someone other than the patient, print name and state relationship and authority

Name of Representative:	**Relationship and Authority:**