

PATIENT INFORMATION

Patient Full Legal Name Date of Birth Last 4 of SSN
Street Address City State ZIP
Phone Number Email Address

RELEASE INFORMATION TO (RECIPIENT)

Recipient Name / Organization Attention / Dept.
Street Address City State ZIP
Phone Fax Email

RECORDS TO BE RELEASED

Check all record types that should be released:

- All Medical Records
- Office Visit Notes
- Lab Results
- Imaging / Radiology
- Operative / Procedure Reports
- Consultation Notes
- Immunization Records
- Discharge Summary
- Medication List
- Mental Health Records
- Substance Use Records
- HIV/AIDS Records

Other records (specify)

Date Range — From To (Leave blank for all dates)

PURPOSE OF RELEASE

- Continuing medical care
- Referral to specialist
- Personal records
- Legal/insurance purposes
- Second opinion
- Other (specify below)

Other purpose (specify)

DELIVERY METHOD

Preferred delivery method: Fax Mail Email Patient pick-up

AUTHORIZATION STATEMENT

I hereby authorize Southern Horizon Healthcare to release the medical records described above. I understand that:

- I may revoke this authorization at any time by submitting a written request to our office, except to the extent that action has already been taken in reliance on this authorization.
- My treatment, payment, enrollment, or eligibility for benefits will NOT be conditioned on signing this form.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
- I have the right to inspect or copy the PHI described in this authorization.
- A photocopy of this authorization is as valid as the original.

EXPIRATION

This authorization expires: 1 year from signing 6 months from signing Upon event:
Expiration event (if selected above)

SIGNATURE

Patient / Authorized Representative Name (print)

Date

If Authorized Representative — Relationship to Patient

Representative Phone

■ Note

Federal law may prohibit re-disclosure of mental health, substance use, or HIV/AIDS records without additional written consent. If you have questions about this form, please contact our office at 469-645-0200 before signing.