Saline Health System
Saline Clinics

For Official Use Only: MR#: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: _____ Date of Birth: _____

1. Who is authorized to disclose the information? _____
2. Who is authorized to receive the information? Name: _____

   Complete Address: _____

   City: _____ State: _____ Zip Code: _____
3. I understand that I may be charged for the costs of copying the information to be released.
4. The specific information to be requested or released is:

   List the dates of service: _____

   ❑ Clinic Report ❑ Lab ❑ Operative Report ❑ Physical ❑ Shot Record ❑ X−Ray Report

   ❑ Other: _____
5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
6. I understand that Saline Clinics may be paid for the cost of copying the information released.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or obtain a copy of any information used/disclosed under this authorization.
8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Saline Clinics except to the extent that action has been taken in reliance on this authorization. **This authorization expires: 1 year from date signed.**
9. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services and/or treatment for alcohols and drug abuse.

PLEASE INCLUDE A COPY OF A PHOTO ID

_____ _____
Signature of Patient or Representative Date

_____ _____
Phone Number Relationship to Patient