Release Authorization

Patient's Name

First Name Last Name

Date of Birth

Last 4 of SSN#

Authorization type

I hereby authorize Centerstone Health Services to...

Reason

- ○ Obtain Information from:
- ○ Release information to:
- ○ Release and obtain information from:

Name

First Name Last Name

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Phone Number

Area Code | Phone Number

Fax Number

Area Code | Phone Number

Relationship

- ☐ Healthcare Provider
- ☐ Client Attorney
- ☐ Self
- ☐ Family
- ☐ Third Party Attorney

Purpose

The above information is released for the following purpose:

- ☐ Continuation of Care
- ☐ Legal Purposes
- ☐ Insurance Purposes
- ☐ Employer Requirement
- ☐ At Patient's Request
- ☐ Other

Type of Information

Information to be released :

- ☐ Cologuard Results
- ☐ Current Dexascan
- ☐ Current Mammogram
- ☐ Current Pulmonary Function Test Results
- ☐ Discharge Summary
- ☐ Consultation
- ☐ Diagnostics
- ☐ Entire Record
- ☐ EKG / Cardiology Report Current
- ☐ ER Report
- ☐ Eye Exams
- ☐ Labs for the last 12 months
- ☐ Last three Pap
- ☐ Operative Report
- ☐ Immunization Record
- ☐ Physician’s Orders/Progress Notes for Last 12 Months
- ☐ Pathology Report(s)
- ☐ Previous Medicare Wellness Visit & Associated Labs Results
- ☐ Radiology Report
- ☐ Sleep Studies

Release Dates

Dates to be released:

☐ All treatment dates

From (Date)

To (Date)

Exclusions

Indicate specific information to be EXCLUDED from this authorization, if any: (Check all that apply)

☐ Mental Health

☐ Genetic Information

☐ Drug & Alcohol

☐ HIV/AIDS

☐ Infectious Disease

Authorization

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange toinspect my health information or obtain copies/electronic media of my health information.I understand that the person(s) and /or organizations(s) listed above whom I am authorizing to use and /or disclose my information may not conditiontreatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Revocation Process: I understandthat I may by placing my request in writing to the Centerstone Health Services revoke this authorization at any time except to the extent that action has beentaken in reliance on it and that in any event this authorization will expire three months from the date of my signature or as otherwise specified by date, event orcondition as follows. Photocopy: I further authorized that a photocopy of this authorization form will be fully acceptable as an original and that CenterstoneHealth, may deny the release of protected health information, if it has reason to believe this authorization has been altered or is not a true and accurateauthorization initiated by the patient. Fees for copies: Federal and state laws permit a fee to be charged for the copying of patient records. You may be requiredto prepay for the copies; if not, then your copies will be mailed along with an invoice.I voluntarily authorize the use or disclosure of my protected health information to Requestor, either verbally, in writing, and/or facsimile, as described above.

Date

Month Day Year

Signature