AUTHORIZATION FOR RELEASE OF INFORMATION

1. I (the undersigned) authorize _____
(Provider/Facility Name)

to release information from the record(s) of Patient: _____
(Last) (First) (MI)

Date of Birth: _____ SSN: _____

Covering the period(s) of treatment: From: **All dates of service**

2. Information to be released (check all that apply):

☒ All records	☐ Admission	☐ Billing	☐ Cath films
☐ CT scans	☐ Claims History	☐ Consultation	☐ Discharge Summary
☐ Echocardiogram Tapes	☐ Education Reports	☐ EKGs	☐ Evaluations & Summaries
☐ Fetal Monitor Strips	☐ History & Physical	☐ Lab Reports	☐ MRI Scans
☐ Nurse's Notes	☐ Progress Notes	☐ Radiation Records	☐ Social History
☐ Ultrasounds	☐ Videos	☐ X-ray Films	☐ X-ray Reports

☒ Complete Medical Record (includes patient forms, information regarding insurance, demographics, referral documents and records from other facilities).

☐ Other: _____

Specific Requestor Information

3. Information to be released to:

4. Purpose of disclosure: **Hero Help Program Compliance**

5. **I understand this consent may be revoked in writing at any time**. With the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed two (2) years from the date of signing. To initiate revocation of this authorization direct all correspondence to the "Specific Requestor" above.

6. I understand the information to be released or disclosed may include information relating to psychiatric/psychotherapy record, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician information, pharmacy information, insurance coverage information, and any other protected health information concerning me.

7. A photocopy of this authorization is to be considered as valid as the original.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.

9. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL: DO NOT RELEASE _____

SIGNATURE: _____ DATE: _____

Patient or personal/legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent or deceased).

PRINT NAME: _____

Relationship to patient or personal/legal representative signing for patient: _____