



Hyndman Area Health Center, Inc.

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Medical/Dental Record Release Authorization

To: Doctor/Hospital: _____

Fax/Telephone: _____

Address: _____

City/State/Zip: _____

I hereby authorize and request you release to _____ the following medical/dental information:

- | | |
|---------------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Complete records/includes current records. | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Pathology Results |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> ER Reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Miscellaneous | <input type="checkbox"/> Dental Records |
| <input type="checkbox"/> CT & MRI Scans | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Nuclear Scans | |

Note: Special dates of interest: _____ to _____.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

The health plan or health care provider must complete the following:

- What is the purpose of the use or disclosure? _____
- Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

The patient or the patient's representative must read and initial the following statements:

- I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials:** _____
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** _____
- I understand that this authorization will expire on ____/____/____. **Initials:** _____
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any affect on any actions they took before they received the revocation. **Initials:** _____

Please print the following:

Patient Name: _____ Maiden Name: _____

SSN: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Signature: _____ Date: _____

Witness: _____ Date: _____