RURAL HEALTH GROUP
healthcare that fits your family

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Expires one (1) year from date signed unless otherwise specified)

I authorize

	Rural Health Group, Inc.

OR

	Name: _____ Contact Name: _____ Phone: _____ Fax #: _____ _____ Address: _____ _____ ***(Name & at least 1 other item required for record release)***

To use or disclose to:

Company Name or Contact Name: _____

Address: _____ City:_____ State: _____ Zip:_____

Telephone: _____ Fax: _____ Contact Name: _____

The protected health information of:

Patient Name: _____ Date of Birth:_____

Address: _____ City:_____ State: _____ Zip:_____

Social Security #: _____ Telephone #: _____

Treatment Dates:_____ RHG Patient #:_____

(If left blank, all dates of service will be released)

****Please put your INITIALS next to the specific documents that you want to have released.**
If you initial the first box, this covers all the other boxes in this section.

	Outpatient Clinic Notes ***(all notes from record)***
	Emergency Department Notes
	History and Physical
	Progress Notes
	Operative/Procedure Notes
	Pathology Reports

	Provider Orders
	Nurses Notes
	Discharge Summary
	Laboratory Reports
	Radiology Reports
	EKG, EEG Reports

	OB/GYN Notes and Labs
	Mammogram Reports
	Billing Reports
	Consultations
	Other:

****Please put your INITIALS next to any SENSITIVE information that you want to have released.**
These categories are not included unless you initial these boxes.

	Drug & Alcohol		Mental Health		HIV/AIDS, other communicable diseases		Genetic Testing

Please put a <u>CHECKMARK ✓</u> next to the purpose of your request*:*

	Attorney/Legal
	Personal Use

	Continued Patient Care
	Social Services/Disability

	Insurance
	Other:

I understand that:

- I may revoke this Authorization at any time:
  - The revocation will not apply to information that has already been released in response to this Authorization.
  - I must revoke this Authorization in writing.
- I may refuse to sign this Authorization. Authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter the patient's ability to receive medical care from any healthcare provider.

I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date or event:

_____

If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

By signing, I acknowledge that this authorization is truly voluntary and that I am the protected patient/guardian or am authorized to act on behalf of the patient to sign this document. I understand that I may request a copy of this authorization once it has been signed.

_____ _____

Patient/Legal Representative** Date

_____ _____

Relationship to Patient Witness

**If the patient is under 18 years of age, unless the patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, legal guardian or other person acting in loco parentis who has the LEGAL authority to act on the minor-patient's behalf. By signing this form for someone else, you as the parent, legal guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.