



HIPAA RELEASE OF INFORMATION

Authorization to Use or Disclose Protected Health Information

RAHC Fax Number: (855) 806-0826

Patient Name: _____	
Date of Birth: _____	Age: _____ SSN: _____
Home Phone: _____	Cell Phone: _____
Address: _____	

I give permission to the Rockbridge Area Health Center to use and (*choose one*):

Send my RAHC records to Receive my records from

Name of Facility or Person	Phone Number/ Fax Number
Street address	City
State	Zip Code

Dates ranging from _____ to _____
If no date has been specified, only provide the last 2 years

I am requesting the following documentation to be released: (check all that apply)

<input type="checkbox"/>	All Records	<input type="checkbox"/>	Physical Therapy Notes	<input type="checkbox"/>	Physician Office Notes	<input type="checkbox"/>	EKG Reports
<input type="checkbox"/>	Lab Results	<input type="checkbox"/>	Immunization Record	<input type="checkbox"/>	Pharmacy Records	<input type="checkbox"/>	Substance Use Disorder
<input type="checkbox"/>	X-Ray Results	<input type="checkbox"/>	Mental Health Record	<input type="checkbox"/>	HIV/AIDS Info	<input type="checkbox"/>	Other:

The purpose for the release of information at the request of the individual is: (check one)

<input type="checkbox"/>	Transfer of Care*	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Self/Personal Copy	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Insurance	<input type="checkbox"/>	Workman's Comp	<input type="checkbox"/>	Attorney	<input type="checkbox"/>	

***If Transfer of Care is checked, RAHC will become my Primary Medical Care Provider.**

I understand that I have the right to revoke this authorization by submitting my request in writing. I further understand that Rockbridge Area Health Center may re-disclose records received under this authorization, except for mental health records which require a separate re-disclosure authorization. I also understand that I may refuse to sign this authorization and it is strictly voluntary. But, I also understand that certain records are needed for the best quality medical care. I fully understand and accept the terms of this authorization which shall remain in effect one year from the date of the request unless otherwise stated.

 Patient/Legal Guardian Signature

 Relationship to Patient

 Date