AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete this form to authorize Cedar Point Health (CPH) to request your personal health information on your behalf. You may revoke this authorization in writing or by contacting medical records at CPH. Once health information is disclosed, the organization that receives it may re-disclose it. Privacy laws may no longer protect it.

PATIENT INFORMATION:	Patient Name: _____ Date of Birth: _____ Phone Number: _____
AUTHORIZATION TO:	☐ Send Information ☐ Request Information
INFORMATION MAY BE RELEASED **FROM**:	Organization: _____ City/State: _____ Phone Number: _____ Fax Number: _____
INFORMATION MAY BE RELEASED **TO**:	Organization: _____ City/State: _____ Phone Number: _____ Fax Number: _____
INFORMATION TO BE RELEASED:	☐ All health information ☐ Radiology ☐ Office Notes ☐ Labs ☐ Pathology Reports ☐ Other: _____ ☐ Immunization Records
	Optional ☐ Health information between the following dates: _____ to _____ ☐ Include psychotherapy notes. To authorize, initial here _____ ☐ Exclude:
AUTHORIZATION ENDS:	☐ On (date): _____ ☐ When the following occurs: _____ *If no date provided, authorization ends one year from signing.
PURPOSE:	☐ Transfer to New Provider ☐ Consult/Referral ☐ Other: _____

_____ _____ _____

PATIENT NAME (PRINT) SIGNATURE DATE

_____ _____

PERSON SIGNING ON BEHALF OF PATIENT RELATIONSHIP TO PATIENT