CorrHealth

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Facility:	Name:
DOB:	Inmate Number:
Date:	Booking Date:

I authorize and request: _____
(Name of Person or Agency Requesting or Releasing Information)

Release Copies of Medical Record To: _____
_____

Obtain Copy of Medical Records From: _____
_____
_____

Purpose of Release: ☐ Continuity of Care ☐ Review of Medications ☐ Other _____

The Extent or Nature of Information to Be: ☐ Released ☐ Requested Time Period From _____ to_____

☐ Entire Medical Record	☐ Lab Work	☐ Radiology
☐ History and Physicals	☐ ER Visits	☐ Medications
☐ Mental Health and Psychiatric	☐ Other _____	

Date Upon Which Authorization Expires: _____ (if left blank will expire in 90 days)

I understand this authorization may be revoked at any time in writing unless action has already been taken based upon it, and that in any event this authorization expires in (90) days from the date signing or upon the condition(s) described above.

_____
Patient Signature Date

_____
Legal Representative/Guardian (Describe authority to act on behalf of Individual) Date

Certain Statutes, State, and Federal may prohibit further disclosure or release of the above information without specific written authorization for release for the person about whom it pertains. This authorization for release of protected health information is not intended to authorize further release of disclosure. Redisclosure of my medical records by those receiving the above information may be accomplished without my further written authorization and my no longer be protected.