GUTHRIE℠

AUTHORIZATION TO REQUEST HEALTH INFORMATION FROM NON-GUTHRIE PROVIDERS

Patient: _____ Date of Birth: ____/____/____

Telephone # : ( ) _____ - _____ SS# : (last 4 digits) XXX - XX - _____

Address: _____

(Street) *(City)* *(State)* *(Zip)*

1. **The following organization is authorized to make the disclosure:**

Name: _____ Telephone:( ) _____ Fax:( ) _____

Address: _____

(Street) *(City)* *(State)* *(Zip)*

2. **Description of information to be disclosed or used**

Dates of treatment: From _____ to _____

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Cardiac Reports
- ☐ Emergency Department
- ☐ Physical Therapy
- ☐ X Ray Reports
- ☐ Other _____
- ☐ Office Notes
- ☐ Immunization Records
- ☐ Lab Results

3. **This information may be disclosed to and used by *The Guthrie Clinic* for continuation of care:**

The Guthrie Clinic Provider/Department/Hospital : _____

Telephone:( ) _____ Fax:( ) _____

Address: _____

(Street) *(City)* *(State)* *(Zip)*

4. I understand that:
   - I may refuse to sign this authorization and that it is strictly voluntary.
   - My refusal to sign this authorization will not affect my ability to obtain treatment, except when health services are solely for the purpose of reporting to a third party.
   - I may revoke this authorization at any time in writing, but if I do, it will not apply to any disclosure already made in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with rights to contest a claim under my policy.
   - Once the information listed above has been disclosed, it may be redisclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.

5. This authorization will expire six months from the date of signing unless I request an earlier date or event here: _____

6. Drug, Alcohol, HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. **Do not release:** ☐ Drug/Alcohol ☐ HIV ☐ Mental Health (Psychiatric)

I have read and understand this authorization and authorize the use and/or disclosure of the protected health information as described in this authorization.

Signature of Patient/Guardian: _____ **Date:** ____/____/____

Relationship to Patient if signed by Guardian: _____