AUTHORIZATION FOR RELEASE OF
PROTECTED PATIENT HEALTH INFORMATION (PHI)

Patient's Name____________________________ D.O.B. _____________________
Daytime Ph #: ____________________________ Cell Ph #: ____________________

Information to be released:

☐Discharge Summary ☐History/Physical ☐Consultation Report ☐ Physical Exam Form
☐Lab results ☐Radiology reports ☐EKGs
☐Operative report ☐Pathology Report ☐Physician Notes\Progress Notes
☐Other ____

Reports originating from another location including ER, Nursing Facility, and Hospital Stay should be requested from the originating facility. Horizon retains primary reports for services performed/ordered at/by Horizon.

Treatment Dates: from______________________ to _________________________

Paper records will be prepared, Or to request a CD (electronic records) please mark box. ☐

Information to be disclosed will be used for: Check the appropriate box (s) and include other info where indicated
☐ Continuation of Care ☐ Insurance ☐ Litigation ☐ Personal ☐ Transfer of Care ☐ Other_______________________

☐ **Release TO Horizon Healthcare****	☐ **Release FROM Horizon Healthcare**
213 NW 10th Street Ste A **Fairfield, IL 62837** **Phone: 618 842-4617 Fax: 618 842-4743** ATTN:___________________________	**213 NW 10th Street Ste A** **Fairfield, IL 62837** **Phone: 618 842-4617 Fax: 618 842-4743** ATTN:______________________________

Name:____
Facility:____
Address:______________________________________City:_________________ State:__________ Zip: ___________
Phone:_______________________________________ FAX (If known)____

****If information is released TO Horizon Healthcare, please return a copy of this form with the materials requested****
IF INFORMATION BEING RELEASED IS MORE THAN 30 PAGES, PLEASE MAIL, DO NOT FAX.

______ **By initialing**, I am releasing the following information that may be included in the record under this authorization: Information related to Sexually Transmitted Infection, Acquired Immunodeficiency Syndrome, or Human Immunodeficiency Virus. It may also include information about behavioral mental health services and treatment for alcohol/drug/substance abuse.

- I understand that I may revoke this authorization at any time by WRITTEN REQUEST
- I understand that the revocation will not apply to information already released in response to this authorization
- A photocopy or facsimile of this authorization will be treated in the same manner as the original, and the healthcare organization may deny release of protected health information, if 1) release is not a true and accurate authorization initiated by the patient or 2) is dated prior to the treatment dates for which records are being requested.
- I understand that once information is released pursuant to this authorization, Horizon Healthcare cannot prevent the re-disclosure of the information to a third party
- I understand that PHI may be used and disclosed to carry out treatment, payment, or healthcare operations.
- I understand I have the right to request that Horizon healthcare restrict how PHI is used or disclosed to carry out treatment, payment or healthcare options. I also understand that in certain circumstances Horizon Healthcare has the right to deny requested restrictions. However, if Horizon Healthcare agrees to a requested restriction it is binding.
- **I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities**

This signed consent form will be kept for a period of six (6) years by Horizon Healthcare. For more information regarding your Privacy rights and responsibilities please refer to the Horizon Healthcare HIPAA Privacy Notice. This Authorization will expire ONE YEAR following the date of signature except in the case of continuing care and is not applicable to future dates of treatment once signed and dated

______________________________________ _____________________ ____________ ___________
Patient/Parent/Legal Responsible Party Relationship Date Time

Identification for pickup is required.

Date Received _____________Date Processed__________ Request Completed by________________________
HORIZON OFFICE USE ONLY: ☐ Picked Up ☐ Faxed ☐ Mailed ☐ Recorded in PHI Log

Rev. 05/21/14