Southcentral Foundation

Release of Protected Health Information/ Authorization Form

Name of customer-owner whose information is to be released:	Date of Birth:	Medical Record #:
Address:	Phone / Contact Number	

I authorize Southcentral Foundation to: (check all that apply) ☐ – RELEASE Information To: ☐ – OBTAIN Information From:

Organization Name	Specify Department, Job Title, or Name of Person to receive information.
Mailing Address:	City/State/Zip
Phone / Contact Number	Fax Number

PROGRAM OR LOCATION OF INFORMATION TO BE RELEASED: (Check each department you are authorizing information to be released from)

☐ Medical Services ☐ Dental ☐ Optometry ☐ Home-Based Services ☐ Behavioral Health ☐ Alcohol/Drug Treatment

INFORMATION TO BE RELEASED: (Check only one)

☐ All Records ☐ Only Specific Dates: From: _____/_____/_____ To: _____/_____/_____

☐ Only Information Pertaining to: (Check all that apply)

☐	Laboratory/Radiology Reports	☐	Medication Lists	☐	Mental Health
☐	History/Physical Examinations	☐	HIV/AIDS, Transmittable Diseases	☐	Treatment Plan
☐	Immunization Records	☐	Sexual Assault Info.	☐	Medication Management Notes
☐	Discharge Summary	☐	Assessments	☐	Alcohol/Drug Treatment
☐	Other: (describe)				

PURPOSE FOR THE RELEASE: ☐ Coordination of Care ☐ Personal ☐ Legal ☐ Other: _____

DURATION OF AUTHORIZATION: (Check ONLY one)

☐ This written authorization shall expire (end) immediately after the information has been released.

☐ This written authorization shall remain valid during the dates listed: From: _____/_____/_____ To: _____/_____/_____

☐ This written authorization shall remain valid until an expiration event has been met: Describe expiration event: _____

I understand that::

- SCF will not condition treatment, payment, enrollment or eligibility for benefits or services if I refuse to sign this form. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, and psychiatric care or other sensitive information.
- I may inspect and receive a copy of this release of information form upon my request;
- I may revoke this release of information at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the SCF Notice of Privacy Practices.
- I understand if the requestor or receiver of the released information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be further disclosed.
- If I am requesting records of a minor child or an incapacitated adult, I must sign this form and include my relationship and authority to sign on their behalf.

I have read the above and voluntarily authorize the release of the protected health information as stated.

Signature of Customer-owner/Parent/ Representative	Date Signed
Printed Name of Customer-owner/Parent/Representative	Relationship to Customer-owner if Parent/Representative