Medical Records Release Form

I _____, authorize use and disclosure of all protected health information, INCLUDING PSYCHIATRIC/MENTAL HEALTH described below to The Hot Springs reTreat Clinic.

This authorization for release of information covers the period of healthcare from past until time of referral to our clinic.

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This medical information may be used by the person/organization I authorize to receive this information, for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or POA: _____

Printed name of patient or POA representative and his/her relationship to patient:

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