Connected Whole Health
at University of Western States

RELEASE OF INFORMATION AUTHORIZATION

Patient Name: _____Date of Birth: _____

Patient Address: _____

Phone: _____Email: _____

Requested patient information:

- ❑ Treatment Notes
- ❑ Laboratory Records
- ❑ Imaging Reports
- ❑ Intake Forms and Health History
- ❑ Patient Update Forms & Outcome Assessments
- ❑ All Medical Records for Specified Period
- ❑ All Billing Records for Specified Period
- ❑ Other _____

Specified **dates of records** requested: From _____/_____/_____to _____/_____/_____

Authorize Statement (Check one)

- ☐ I authorize the clinic to release my medical records directly to me.
- ☐ I authorize the clinic to release my medical records to the medical provider or individual listed below:

Name: _____

Address: _____

Phone #: _____Fax #: _____

Delivery Information (Check one)

- ☐ I prefer to pick up my records.
- ☐ I prefer to have my records mailed directly to me at the address listed above.
- ☐ Please fax or mail my records to the medical provider or individual indicated above.
- ☐ Please email the records directly to me. I am aware that email is not a secure platform for transmitting health data and **will not hold the clinic liable**.

I understand the following:

- The information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AID), or human immunodeficiency virus (HIV), and alcohol and drug use. I authorize the release or disclosure of this type of information.
- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. (Please see the Notice of Privacy Practices).
- The information released in response to this authorization may be re-disclosed to other parties.
- Any facsimile, copy or photocopy of this authorization shall authorize the provider to release the records requested herein.
- This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.
- Fees are based on local state and federal regulations and will not exceed the amount of $25.

_____ _____

Patient Signature or Legally Authorized Representative with Title Date

I certify that I have legal authority under federal and state laws to make this request on behalf of the patient indicated above

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