Real Solutions to Fit Your Needs

Grinstead & Associates

RECORD RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO INCLUDE SUPER CONFIDENTIAL PHI

I, _____, (Name of Patient making Request), hereby request an copy of my health records and authorize **Grinstead & Associates**, (hereafter collectively referred to as "this Healthcare Facility") to use and disclose a copy of my health records to _____

I prefer my records be sent in the following format, but understand that by law, the records can be sent in any electronic format similar if the format I desire is not available. I know this Healthcare Facility will supply these records within **30 days** of this request and will contact me should there be any reason they need to extend this time frame. I understand, by law this Healthcare Facility can request an extension for more time but, can only request an extension, once for an additional 30 days. The format which I prefer to have my electronic records sent is.

☐ Email a word document to (email address): _____
☐ Fax a copy to (fax number): _____
☐ Send a hard copy to (address: _____
☐ I will pick up a copy on or after (date): _____
☐ Phone calls
☐ Appointments (verify or make) ☐ Payments (call and check balance and pay)

I understand that the information to be released may include information in the following categories unless I specifically deny the release (initial any category **not** to be released.

_____HIV records (including HIV test results) and sexually transmissible diseases
_____Alcohol and substance abuse diagnosis and treatment records
_____Psychotherapy records summary

The undersigned does hereby release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

By Patient: _____ Date: _____
Print Name

_____
Sign Name

or
Patient's Representative: _____ Date: _____
Print Name

_____
Sign Name