COPLIN
HEALTH SYSTEMS

Medical Information Release

This release allows us to obtain your health records from your provider.

Office Use Only	From:	To:

This information may be: Picked Up ☐ Faxed ☐ Mailed ☐

Patient's Name:	Date Of Birth:
Address:	
City, State, Zip:	
Phone:	

This release is for continuity of care and does not reflect a change in the patient's primary care provider.

I understand that this authorization shall remain in effect for **one (1) year** from the date of my signature below unless an earlier expiration date is specified in this space _____. I also understand that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved. I further agree that Coplin Health Systems, or its agent, may charge me or any designated recipients cost incurred in preparing the copy of the requested records.

Records to be released: Please **INITIAL** beside any applicable information to be released.

(Note: If psychiatric/mental health, alcohol/other drug, or HIV/AIDS information is contained within the record(s), no part of the record(s) can be released unless the categories are marked appropriately.)

_____ Pap Smear	Doctor/office _____
_____ EKG Report	Doctor/office _____
_____ Colonoscopy	Doctor/office _____
_____ Bone Density Scan	Doctor/office _____
_____ Diabetic foot exam	Doctor/office _____
_____ Mammogram	Doctor/office _____
_____ Immunizations	Doctor/office _____
_____ Dilated Retinal Eye Exam	Doctor/office _____
_____ Office Notes	Doctor/office _____
_____ Labs	Doctor/office _____
_____ Operative/Procedure Reports	Doctor/office _____
_____ Radiology Reports	Doctor/office _____
_____ Pathology	Doctor/office _____
_____ Psychiatric/Mental Health Notes	Doctor/office _____
_____ Alcohol/Drugs	Doctor/office _____
_____ HIV/AIDS	Doctor/office _____
_____ ER Records	Doctor/office _____
_____ All	Doctor/office _____

Dates of Most Recent Treatment(s): _____

SIGNATURE OF PATIENT OR GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____ **DATE:** _____

WITNESS: _____

If the above signature is not that of the patient, explanation will be provided and documentation of guardianship, power of attorney or executor may be required to accompany this authorization.

PROHIBITION ON RE-DISCLOSURE OF PATIENT INFORMATION regarding psychiatric, alcohol and other drug, HIV/AIDS and other categories specifically protected by State and Federal laws:

This notice accompanies a disclosure of patient information specifically protected by State and Federal confidentiality laws. This information is disclosed to you with the expressed written consent of the patient. The law prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal or State law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient.