Thundermist HEALTH CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By completing and signing this form, Thundermist Health Center and its affiliates (e.g., subsidiaries, agents, employees) are authorized to disclose my protected health information (PHI) to the individuals or entities listed below.

Please complete all sections of this form.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ ZIP code: _____

Purpose of Release:

Please check the appropriate box or specify another purpose.

☐ Treatment/ Continuing Care ☐ Transfer of Care ☐ Legal ☐ Personal use

☐ Disability Determination ☐ Employment ☐ Other (please specify): _____

Where should Thundermist send your records? (Please complete in full)

To: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____

Delivery Method: ☐ Pick up paper copy OR ☐ Secure email copy to _____

Specific Dates of Service(s) Requesting _____ To _____

☐ Progress/Consult Notes ☐ Laboratory Reports ☐ X- Ray Reports ☐ Dental Records

☐ Abstract Records (Last 2 years Medical Summary, Progress Notes/TeleVisits, Lab/X-Ray Reports, Special Studies)

☐ Complete Record (Last 10 years)

Thundermist Health Center does not provide records from other healthcare offices. Please request them directly from the original provider.

I understand my medical record may contain sensitive information. My checkmark(s) below indicates that I **do not** permit this information to be released.

Do Not Include:

☐ Treatment for HIV/AIDS

☐ Substance Use and/or Treatment

☐ Transgender Information and/or Care

☐ Behavioral Health Treatment

☐ STD/STI, Testing, Diagnosis, and/or Treatment

Unless I checked a box above, I understand that behavioral health information and medication lists will be released. I understand I may revoke this authorization in writing before any records are released. Thundermist Health Center will not condition treatment, payment, enrollment, or care eligibility on my decision to sign this authorization.

If the recipient is not a healthcare or health plan provider, my information may no longer be protected by federal privacy regulations. I also understand that I may be charged a fee for this request, as allowed by law.

My signature confirms consent for the use or disclosure of PHI above. This authorization expires one year from the date signed.

Signature of Patient:	Date:
Or Signature of Authorized Representative:	Date:
Printed name of Authorized Representative:	Phone Number of Authorized Representative:
Relationship to Patient or Representative's Legal Authority to act on Patient's Behalf:	