HORIZON Health Care, Inc.

Horizon Health Care Medical Records
PO Box 99
Howard, SD 57349
P: 605.772.4950 F: 866.423.6811

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

All highlighted sections must be filled out completely or release will not be processed.

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME(s) USED

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____ DATE OF BIRTH: ____/____/____ SS#: _____-_____-____

I hereby authorize the release of information from my medical records as indicated below.

RELEASE INFORMATION FROM:

PROVIDER/FACILITY NAME: Horizon Healthcare
ADDRESS: PO Box 99
CITY/STATE/ZIP: Howard, SD 57349
PHONE: 605-772-4950 FAX: 866-423-6811

RELEASE INFORMATION TO:

PROVIDER/FACILITY NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

☐ LAB REPORT ☐ HIV RELATED INFORMATION ☐ PROGRESS NOTES ☐ OTHER: _____
☐ XRAY REPORTS ☐ IMMUNIZATION RECORD ☐ FAMILY PLANNING ☐ DENTAL RECORDS ☐ MENTAL HEALTH ☐ PAST 2 YEARS

☐ **I do not wish to release records containing information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment, or Family Planning information.**
Signature: _____

PURPOSE OF DISCLOSURE:

☐ CHANGING PHYSICIANS ☐ CONTINUING CARE ☐ INSPECATION ☐ LEGAL ☐ SCHOOL ☐ INSURANCE ☐ CONSULTATION
☐ DISABILITY DETERMINATION ☐ PERSONAL ☐ WORK COMP. ☐ OTHER: _____

REQUESTED DATES OF INFORMATION: _____ TO _____

**** RECORDS FOR THE LAST 2 YEARS WILL BE RELEASED IF DATES NOT SPECIFIED****

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- The Health Center may not condition my treatment on my provision of this authorization.
- This authorization is valid for a 365 day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as valid as the original.
- The Health Center, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship to patient if signed by Legal Representative

Delivery Method: ☐ Faxed ☐ Mailed ☐ Pick Up Format: ☐ Paper ☐ CD

ACKNOWLEDGMENT OF RECEIPT

Patient's Name (Please Print): _____ Signature: _____ Date: _____

Staff Acknowledgment: _____ Date: _____