|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **Patient’s Last** | | **Patient’s First** | | | **Date of Birth** | |
| **2** | 🞎 Please send records from Chapa-De  (To Person/Facility Below) \*Processed within 15 days | | | | 🞎 Please release records to Chapa-De  (From Person/Facility Below) | | |
| **3** | **Full Name of Organization/Provider/Individual (or Self)** | | | | | | |
| **Address** | | | | | | **City** |
| **State** | **Zip** | | **Phone number starting with area code** | | | |
| **Send to:** □ Mail □ Email: □ Fax: | | | | | | |
| **4** | **CHOOSE ONLY ONE (1) Per Release**  \_\_\_\_ Medical \_\_\_\_ HIV/AIDS Testing/Treatment \_\_\_\_ Alcohol/Drug Use Treatment  \_\_\_\_ Dental \_\_\_\_ Behavioral Health \_\_\_\_ Optometry | | | | | | |
| **5** | **Time Frame:** □ Last Visit □ Past Year □ All □ Specific Date Range: | | | | | | |
| **6** | □ Progress Notes □ Last Physical □ Medication List □ Immunization Records □ EKG Reports  □ Consult Reports □ Radiology Reports □ Lab Reports □ Charges/Payments □ Dental X-rays  □ All records of visits □ Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | | | | |
| **7** | **Reason for release:** □ Personal □ Transfer of Care □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Authorization** | By signing, I authorize use/disclosure of my health information and understand that:   * I may revoke this authorization at any time by contacting Chapa-De in writing. * This authorization is valid for 1 year maximum or this earlier date: \_\_\_/\_\_\_/\_\_\_\_. * The recipient of your health information may not further disclose your information without obtaining another authorization from you. * All Alcohol & Substance abuse health information is protected and only releasable with a separate express written consent of the person it pertains to. * My treatment/eligibility of care is not based on this authorization. * This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original. * I have the right to a copy of this authorization. | | | | | | |
| **SECTIONS 1-7 MUST BE COMPLETED TO BE VALID** | | | | | | | |
| **Signature**  🗶\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_Tel:(\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_  **If not patient:** □ Patient’s Representative (State Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | | | | | | |

Internal Use Only: 🞎 Completed \_\_\_/\_\_\_/\_\_\_\_ By:🗶\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_