LEGACY COMMUNITY HEALTH

RELEASE OF INFORMATION AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

Person Requesting: _____ Relationship to Patient: _____
(if not patient)

Phone Number: _____ I.D. #: _____ I.D. Type: _____

I authorize Legacy Community Health to...
SEND records to:

Person/Organization: _____

Address: _____

_____ City _____ State _____ Zip

Phone #: _____ Fax #: _____

Email address: _____

Send by: ☐ Download ☐ Fax ☐ Mail

I authorize Legacy Community Health to...
RECEIVE records from:

Person/Organization: _____

Address: _____

_____ City _____ State _____ Zip

Phone #: _____ Fax #: _____

Email address: _____

Send by: ☐ Fax ☐ Mail (paper)

Date Range of Requested Records: _____ to _____

INFORMATION TO BE DISCLOSED (required)		
☐ Entire Electronic Record	☐ Labs/Diagnostics	☐ Dental
☐ Office Visits	☐ Immunizations	☐ Vision
☐ Status Letter: _____ *Description*		
☐ Other: _____		

PURPOSE OF DISCLOSURE (required)	
☐ Continued Medical Care	☐ Patient Request
☐ S.S. Disability Determination	☐ Legal or Judicial Proceeding
☐ Other: _____	

SENSITIVE INFORMATION NOTICE: Unless indicated otherwise in the section above, the information specified to be released may include, but is not limited to: behavioral health or mental illness, history, diagnosis, and/or treatment of substance abuse, and/or communicable diseases, including HIV and AIDS.

RIGHTS REGARDING AUTHORIZATION: Patients, or their legally authorized representative, have a right to inspect or receive a copy of the health information to be disclosed. Patients, or their legally authorized representative, have a right to withdraw this authorization. Written notification is necessary to withdraw this authorization. This authorization will be valid for the earlier of one year or until the request for health information is fulfilled, unless revoked in writing by the patient or their legally authorized representative. Legacy Community Health will not condition treatment, payment, and/or enrollment or eligibility for benefits on completion of this form. I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law.

FOR MORE INFORMATION: Visit us online at **legacycommunityhealth.org/ROI** or at the Legacy Community Health clinic nearest you.

_____ _____ _____
Signature of Patient or Legal Representative PRINT Name Date

MAIL to: Release of Information, Legacy Community Health, P.O. Box 66308, Houston, TX 77266
FAX to: (832) 548-5092 (Medical Records) **EMAIL to:** mrecords@legacycommunityhealth.org

Orig 10/13, Rev 11/14; 4/15; 11/15; 3/16; 3/17; 6/17; 8/17; 10/17; 4/18; 7/20