

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:	Date of Birth:
Address:	Last 4 of SSN:
City, State, Zip:	Phone: ()
E-mail:	

<p>RELEASE FROM (check all that apply):</p> <p><input type="checkbox"/> Monarch (all locations, except those listed below)</p> <p><input type="checkbox"/> DWI Program or MAT Program</p> <p><input type="checkbox"/> Tanglewood Arbor</p>	<p>RELEASE TO:</p> <p>Name of Individual:</p> <p>Name of Organization:</p> <p>Street Address or P.O. Box:</p> <p>City, State, Zip:</p> <p>Fax:</p> <p>E-mail:</p>
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REASON FOR RELEASE (check all that apply):		
<input type="checkbox"/> Personal	<input type="checkbox"/> Legal	<input type="checkbox"/> Continued Patient Care
<input type="checkbox"/> Insurance	<input type="checkbox"/> Personal Injury/Social Security	<input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Other (specify): _____		

DATES OF RECORDS TO RELEASE (check one):	
<input type="checkbox"/> All Dates	<input type="checkbox"/> From ___/___/___ to ___/___/___

WHAT TO RELEASE (check all that apply):		
<input type="checkbox"/> All Records <small>(not including psychotherapy notes)</small>	<input type="checkbox"/> Comprehensive Clinical Assessments	<input type="checkbox"/> Dates/Times/Locations of Treatment
<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> Medication Reports	<input type="checkbox"/> Service Notes
<input type="checkbox"/> Other (specify): _____		

DELIVERY METHOD (check all that apply; charges may apply):		
<input type="checkbox"/> U.S. Mail	<input type="checkbox"/> Encrypted E-mail <small>(this may require setting up an account)</small>	<input type="checkbox"/> Fax
<input type="checkbox"/> Other (specify): _____		

I understand that:

- I can cancel this authorization at any time. I must cancel in writing and send or deliver the cancellation to Monarch. Any cancellation will apply only to information not yet released by Monarch.
- This is a full release, including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Monarch may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form, upon request.

This permission expires one year after the date of my signature, unless another date or event is written here: _____

If you are requesting your own records:	If you are requesting records on behalf of another person:
Signature:	Signature:
Print Name:	Print Name:
Date:	Date:
	Relationship to Patient (written proof may be required):
	<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Executor/Administrator
	<input type="checkbox"/> Healthcare Agent <input type="checkbox"/> Other (specify): _____