CHA Health Plan

Authorization for Release of Medical Information

Member Name: _____

Social Security: _____ Date of Birth: _____

I allow_____ (PCP/Facility) to release part or all of my medical records. **This includes:**

- alcohol and drug records
- mental health records
- information given by me to social workers or psychologists

This information is needed for the following reason(s):

_____

Please select one of the options below:

☐ I agree to release of my records. May include records listed above.

☐ I do not want these items below released with my records:

- ☐ Alcohol record/info
- ☐ Drug record/info
- ☐ Mental Health record/info
- ☐ Report/information from psychologist(s) and/or social worker(s)
- ☐ Other. Please list here: _____

Please release a copy of my medical records to:

Name	**Address**	**Telephone Number**

By signing this, I understand that:

- I waive the private status of my records for the reason above.
- This consent shall be in effect for one year or through this treatment. Whichever is longer.
- I may cancel this at any time by written notice to the above provider and the Plan.

I have read and understand this form and its contents.

_____ _____
Signature of Patient (guardian, if patient unable to sign) Date

_____ _____
Relation to patient, if signed by guardian Date

_____ _____
Witness Date