RIGGS COMMUNITY HEALTH CENTER
1716 Hartford St
Lafayette, IN 47904
Phone # (765) 742-1567 Fax # (765) 742-2750

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL RECORDS

Patient Name (print)_____DOB_____

Address_____ City, State, ZIP_____

SSN (optional) _____-_____-_____ Phone #_____

I Authorize Riggs Community Health Center (Riggs CHC) to ☑ Release to ☐ Obtain from

Facility/Dr. _____

Address_____

City, State, ZIP_____

Phone #_____ Fax #_____

Purpose for Release _____

If records are for yourself, would you like them in ☐ paper or ☐ CD format?

INFORMATION TO BE RELEASED:

☐ Visit Notes ☐ Labs ☐ Radiology Reports ☐ Shot Record ☐ Physical Form
☐ Medication List ☐ Entire Record ☐ Other (specify) _____

Unless I initial here, _____ I understand that my records may contain information pertaining to Mental Health, Communicable Disease, or Drug/Alcohol Abuse information.

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that Riggs CHC will not deny treatment, payment, enrollment, or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.

This authorization will expire in sixty (60) days unless otherwise specified: _____
You may revoke this authorization anytime in writing by notifying Riggs CHC. The revocation will be effective upon receipt by Riggs CHC unless Riggs CHC has already taken action in reliance of this authorization.

Signed_____ Date_____

Printed name of signee and relationship (if other than patient) _____