Authorization to Release / Request Medical Records

HIPAA-compliant release of information. This authorization is voluntary. Refusal will not affect your treatment.

■ Type of Request

SELECT ONE OR MORE*

- ☐ Release records FROM Rubi Health TO another party
- ☐ Request records FROM another provider TO Rubi Health
- ☐ Both

■ Patient Information

PATIENT FULL NAME* | DATE OF BIRTH* | LAST 4 SSN (VERIFICATION)

PHONE* | ADDRESS

■ Authorize Release From (Source of Records)

PROVIDER / FACILITY NAME* | PHONE | FAX

PROVIDER / FACILITY ADDRESS

■ Send Records To (Recipient)

RECIPIENT NAME / PRACTICE* | PHONE / FAX | PREFERRED DELIVERY METHOD

RECIPIENT ADDRESS | RECIPIENT EMAIL (IF SECURE EMAIL)

■ Information to Be Released

TYPE OF RECORDS — CHECK ALL THAT APPLY:

- ☐ Complete medical record
- ☐ Office visit notes
- ☐ Lab / pathology results
- ☐ Imaging / radiology reports
- ☐ Medication list / prescriptions
- ☐ Immunization records
- ☐ Referral letters
- ☐ Operative / procedure notes
- ☐ Discharge summary
- ☐ Mental health records
- ☐ Substance use records
- ☐ HIV / STI records
- ☐ Billing records

DATE RANGE: FROM | DATE RANGE: TO | PURPOSE / REASON FOR RELEASE*

ADDITIONAL INSTRUCTIONS / SPECIFIC RECORDS NEEDED

■ Expiration of Authorization

THIS AUTHORIZATION EXPIRES:

- ☐ One year from date signed
- ☐ Upon completion of the request
- ☐ On a specific date

SPECIFIC EXPIRATION DATE (IF APPLICABLE)

■ Patient Rights:
You have the right to revoke this authorization at any time in writing. Information released may be re-disclosed by the recipient and may no longer be protected by HIPAA. Signing is not a condition of receiving treatment.

■ Patient Authorization

I understand and voluntarily authorize the release of information described above.

PATIENT SIGNATURE (TYPE FULL NAME)*

DATE*

REPRESENTATIVE NAME (IF APPLICABLE)

RELATIONSHIP / AUTHORITY