ProHEALTH℠
Part of Optum®

AUTHORIZATION FOR THE RELEASE OF INFORMATION

By signing this form, I authorize ProHEALTH to release the medical records of:

Patient's full name:_____ Date of Birth_____/_____/_____

Address: _____

City:_____ State:_____ Zip Code:_____ Phone: ( )_____

Release records to:

Recipient(s) _____

Address: _____

City:_____ State:_____ Zip Code:_____ Phone: ( )_____

Information to be released:

- ☐ Medical Record for past 3 years
- ☐ Date(s) of Service:_____ to _____
- ☐ Entire Medical Record *(including billing, radiology studies and records from prior providers)*
- ☐ Medical History, Evaluation Records
- ☐ Radiology Reports
- ☐ Laboratory Results
- ☐ Cardiology Results
- ☐ Immunizations
- ☐ Prescription Data
- ☐ Consultation Documentation
- ☐ Surgical Reports
- ☐ Summary of Record
- ☐ Other (specify): _____

ProHEALTH Provider or Clinic Name: _____

I understand that the records released may include sensitive information including mental health, substance use disorder, HIV/AIDS, communicable and sexually transmitted disease, and genetic testing.

Reason for the Release of Information:

- ☐ At the request of the individual (Patient)
- ☐ Other (specify): _____

Revocation: I have the right to revoke this authorization at any time by writing to ProHEALTH. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Redisclosure: I understand that the information released according to this authorization may be subject to redisclosure by the recipient(s) and no longer protected under HIPAA federal law.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Signature of Patient *(*or representative authorized by law)*:_____

Print Name:_____

Relationship *(if you are not the patient)*:_____ **Today's Date:**_____

Expiration Date/Event:_____ *(If none specified, the Authorization remains valid for one year from the date of signature).*

**ProHEALTH may require court documentation verifying your authority to sign on behalf of the patient.*

Office use only: Date received:_____/_____/_____ Received by (Print Name/Initial):_____

Ticket:_____ Date completed:_____/_____/_____ ❑Faxed ❑Mailed ❑Emailed ❑Picked up

Kindly complete the form in its entirety and return completed form to the address or fax number listed below. If you need additional information or have questions, you may contact us at the telephone number listed below.

ProHEALTH Health Information Management Department
3 Dakota Drive, Suite 210
Lake Success, NY 11042
Phone: 516-622-3491 Fax: 516-812-4305