OUR HOUSE, INC.

AUTHORIZATION FOR THE RELEASE OF RECORDS
CONTAINING INDIVIDUAL HEALTH INFORMATION

Our House, Inc. is hereby authorized to disclose individually identifiable health information as described below:

_____

Served Individual's Name (Please print) Date of Birth

Name & address of person(s) or organization(s) requesting records, if different than served individual:

_____
_____
_____

Name & address of person(s) or organization(s) to receive the records:

_____
_____
_____
_____

☐ The records will be viewed at Our House, Inc.

☐ The following records are to be copied and will be picked up at Our House, Inc.

☐ A copy of the following records is to be mailed to the above address.

The request is for the following records from the served individual's medical record that were created between _____ and _____:

Identify specific medical records requested:_____

_____

_____

Purpose for which records will be used:_____

_____

_____

Legal Authority for request:

☐ The requestor is his/her own guardian.

☐ The requestor is the legal guardian of the served individual noted above and has attached to this authorization a valid appointment of guardianship.

☐ The requestor is the served individual's attorney-in-fact, and has attached a valid judicial order or signed release from the served individual or the served individual's legal guardian to this authorization that grants the power to request the served individual's medical records.

Understandings and Agreements

1. This authorization is voluntary and I understand that Our House, Inc. cannot condition treatment based on the signing of this authorization, unless the authorization is (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.
2. This authorization will expire when services are no longer rendered or a change request is made from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying Our House, Inc. in writing, but if I do, it will not have any effect on any actions taken prior to the receipt of the revocation.
4. I agree to waive all claims against the facility for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by Our House, Inc. if the recipient of the information is not a health plan, health care provider, healthcare clearinghouse, or a business associate that has a contract with Our House, Inc.
6. I understand that if I request that records be copied and sent to me that Our House, Inc. will make a good faith effort to send those records to me in a reasonable amount of time.
7. I understand that if I wish to have copied of records made, then Our House, Inc. may assess a fee for copying the records.

_____ _____

*Signature of person making request Date

_____

Printed name of person making request

*If "mark" is provided:

Witness signature:_____

Witness Name (Print): _____