



204a – Authorization to Release Medical Records from NON- AHN facility to AHN

(This form can be used if another healthcare provider requires written patient authorization to obtain patient records needed by AHN)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

RECORDS TO BE RELEASED FROM:

Name of HealthCare Provider: _____

Address: _____

I hereby request and authorize the above named Healthcare Provider to release records to:

American Health Network ("AHN") located at: American Health Network
4074 Gantz Road, Grove City, OH 43123
614-871-8500

At my request _____, or for the purpose of: _____

The records of:

Patient Name _____
Print: Last First Middle/Maiden

Address _____
Street City State Zip

Telephone: _____ Date of Birth _____ Social Security No. _____

Please release the following information (check those that apply):

Table with 2 columns and 4 rows: Provider notes, Special Diagnostic test results, Lab reports, Billing records, X-ray reports, Chemical/Alcohol Treatment records, ALL Medical Records, Other (specify)

Unless I HAVE LIMITED BELOW, I understand that this also pertains to records regarding testing and treatment for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, and for psychiatric treatment or counseling or communicable disease. Limitations: _____

Confine to summary information from records regarding treatment for following condition or injury:
On or about (date(s)) _____

1. Other: _____

I UNDERSTAND (1) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT, AS DESCRIBED IN THE PROVIDER'S PRIVACY NOTICE. (2) THAT THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE. (3) THAT THE RECIPIENT OF THESE RECORDS MAY FURTHER DISCLOSE INFORMATION BECAUSE OF THIS AUTHORIZATION AND THEN IT MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT THE PROVIDER WOULD NOT BE RESPONSIBLE FOR THIS ACTION, and (4) I AM ENTITLED TO ASK FOR A COPY OF THIS DOCUMENT.

Date _____

Signature _____

If patient

Expiration (if none, at 60 days): _____

Signature _____

(Parent/Guardian/Legal Representative, if patient unable to sign- Relationship)