American Health Network

(This form can be used if another healthcare provider requires written pateint 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, Last 4 digits Only_____

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

Provider notes	☐	X-ray reports	☐
Special Diagnostic test results	☐	Chemical/Alcohol Treatment records	☐
Lab reports	☐	**ALL Medical Records**	☐
Billing 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)