



HCR MANOR CARE

AUTHORIZATION FOR THE  
RELEASE OF HEALTH INFORMATION RECORDS

- I am the patient noted above.
- I am the patient's legal decision maker under state law and I am entitled to receive the medical records under state law.
- I am the patient's attorney-in-fact, and I have attached to this authorization a valid Power of Attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the patient's medical records.
- I am the patient's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.
- If the patient is deceased: I am the executor/administrator of the patient's estate, and I have attached to this authorization a valid appointment as such from a probate court.
- The patient has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of that instrument to this authorization.
- The patient's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the patient's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so (e.g., a power of attorney or probate court order).

**Understandings and Agreements of Requestor**

1. This authorization is voluntary.
2. This authorization will expire two months from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying the Provider in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the Provider 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 the Provider if the recipient of the information is not a health plan, health care Provider, health care clearinghouse, or a business associate that has a contract with the Provider.
6. The Provider may not place conditions on treatment, payment, enrollment or eligibility for benefits on whether I sign an authorization when the prohibition on conditioning of authorizations applies.
7. I understand that I must provide the Provider with at least twenty-four (24) hours notice before coming to the Provider's location to review records.

HCR MANOR CARE

AUTHORIZATION FOR THE  
RELEASE OF HEALTH INFORMATION RECORDS

- 8. I understand that after I have reviewed the records, I must provide the Provider with two (2) working days advance notice of any copies of the records that I would like to pick up at the Provider's location.
- 9. I understand that if I request that records be copied and sent to me that the Provider will make a good faith effort to send those records to me in reasonable amount of time.
- 10. I understand that if I wish to have copies of records made, then the Provider will assess a fee for copying the records.
- 11. The Provider will notify me of the total amount due for copying and shipping of the requested records; I agree that the Provider will only send me the requested information once it has received payment in full for those costs.

---

Signature of Requestor	Print Name	Date
------------------------	------------	------