AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Organization Releasing Information:

____ Patient Name: ____________________________________

____ (Other Names) __________________ DOB: _____________

____ Medical Record #: __________________

The undersigned hereby authorizes the above-identified hospital or clinic to release health information to :

____
(NAME OR TITLE OF PERSON OR ORGANIZATION)

____
(ADDRESS)

The information is to be released for the following purpose:

☐ Continuing Care ☐ Litigation ☐ Insurance Claim (s) ☐ Other (Explain) ________________________

This authorization to disclose health information is limited to the following:

☐ 1. Indicate the time periods (dates) for which these records are being released:

From ______________________________ to __________________________________

☐ 2. Specific information from my medical record:

☐ History and Physical ☐ X-ray Report(s)

☐ Discharge Summary ☐ Laboratory Report(s)

☐ Operative Report(s) ☐ Other____

☐ Pathology Report(s) ☐ Clinic Visit(s)

☐ Consultation Report(s) ☐ Entire record

I understand that the information in my health record may include information relative to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____. If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date I signed it.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer.

____ ____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT IF SIGNED BY LEGAL REPRESENTATIVE

____ ____
DATE OF PATIENT'S SIGNATURE WITNESS