Providence Hospital
6801 Airport Boulevard Mobile, Al 36608

MR NO: _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

IN ORDER FOR THIS AUTHORIZATION TO BE VALID ALL BLANKS MUST BE COMPLETED

I, (PATIENT NAME) _____ SSN: _____
and born _____, _____, hereby authorize and consent to allow *PROVIDENCE HOSPITAL* to disclose information contained in, provide access to, or provide such photocopies as may be requested of my Protected Health/Billing Information to the person or organization listed below:

ADMISSION/DISCHARGE DATES: _____
E.R. TREATMENT DATE: _____

The persons or class of persons that my Protected Health Information may be released to:
PERSON(S): _____ COMPANY: _____
ADDRESS: _____ CITY/STATE/ZIP: _____

The purpose or need for this release of information is:

_____

The specific information to be used or disclosed is:

❑ FACE SHEET	❑ LABORATORY REPORTS	❑ PROGRESS NOTES	❑ HEART CATH
❑ HISTORY & PHYSICAL	❑ X-RAY REPORTS	❑ PHYSICIANS' ORDERS	❑ ENTIRE CHART
❑ DISCHARGE SUMMARY	❑ X-RAY FILMS	❑ NURSES' NOTES	❑ DETAIL BILLING
❑ CONSULTATIONS	❑ PATHOLOGY	❑ OPERATIVE REPORT	❑ ER RECORDS
❑ OTHER	PLEASE SPECIFY: _____		

I hereby release *PROVIDENCE HOSPITAL* and its staff from all legal responsibility or liability, which may arise from the release of or reproduction of such Protected Health/Billing Information to the recipient. I understand my protected health information that is used or disclosed by this authorization may be subject to redisclosure by the recipient, and the law will no longer protect the privacy of my Protected Health Information. I understand that Providence Hospital is entitled to request and receive reasonable fees for providing such photocopies of my medical record(s) as may be requested as a condition precedent to their release.

I understand that this consent is subject to written revocation by me at any time except in those circumstances in which PROVIDENCE *HOSPITAL* or its staff has taken action in reliance of it. A revocation should be sent to Providence Medical Records Manager P.O. Box 850429 Mobile, Al 36685. Without such written express revocation, this consent will expire on the following date: _____.
If a date is not specified, this consent will expire 1 (one) year from the date of signature.

The patient must sign authorization. If the patient is a minor or is an incompetent adult, their guardian must sign authorization. If there is no guardian appointed by the Court, the authorization must be signed by the nearest relative. If the patient is unable to sign this authorization, please state the reason: _____.

THIS CONSENT AND AUTHORIZATION MAY INCLUDE, BUT IS NOT LIMITEDTO THE RELEASE OF PSYCHOLOGICAL, PSYCHIATRIC, ALCOHOL, DRUG ABUSE AND HIV/AIDS INFORMATION.

_____ _____
Signature of Patient or Representative Date Signed

_____
Relationship (If other than Patient)

_____ _____
Address Witness Signature Date Signed

_____
City, State

_____
Zip Code Telephone

THIS FORM IS IN COMPLIANCE WITH TITLE 42, CFR, PART III AND HIPAA REGULATIONS

FOR MEDICAL RECORD USE ONLY, PLEASE DO NOT WRITE BELOW THIS POINT.