ROI0502

Authorization To Disclose Protected Health Information

FOR INTERNAL USE ONLY

MRN: _____

FIN (most recent): _____

Date Received: _____ Date Completed: _____

Completed By: _____

I authorize the release of protected health information to be disclosed and used by the following:

TO (Receiving Facility):	**FROM (Releasing Facility):**
Name: _____	Name: _____
Address: _____	Address: _____
City: _____	City: _____
State, Zip: _____	State, Zip: _____
Phone#: _____	Phone#: _____
Fax #: _____	Fax #: _____

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Social Security Number: _____ Daytime Phone Number: _____

I request to receive my medical records via:

- ❑ Pick up
- ❑ U.S. Postal Service /Mail
- ❑ Electronically: please provide email address _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The type and amount of information to be used or disclosed is as follows, including dates:

REPORT TYPE:	**DATE(S):**	**REPORT TYPE:**	**DATE(S):**
❑ Facesheet	_____	❑ Progress notes	_____
❑ Discharge Summary	_____	❑ Physician orders	_____
❑ History & Physical	_____	❑ Lab report	_____
❑ Emergency Dept. record	_____	❑ X-Ray report	_____
❑ Consultation report	_____	❑ Fetal monitor strip	_____
❑ Operative report	_____	❑ Entire record	_____
❑ Anesthesia/Surgery report	_____	❑ Other, specify _____	_____

3. I understand that the information in my health record may include information relating 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.

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4. The purpose for the use / disclosure of this information is:
   - ❑ Patient / Personal Representative
   - ❑ Physician Care
   - ❑ Legal
   - ❑ Insurance
   - ❑ Other, Specify _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management 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 in six (6) months.

6. 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 assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure information carries with it the potential for an un-authorization re-disclosure 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 Health Information Management Department or Privacy Officer.

_____ _____

Signature of Patient or Legal Representative | Date | Time

_____ _____

If signed by Legal Representative, Relationship to Patient | Signature of Witness

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For External Use Only

Identification of Patient or Personal Representative:

- ❑ Driver's license
- ❑ Work photo badge
- ❑ Other photo ID
- ❑ Social Security Number
- ❑ Two utility bills
- ❑ Notarized signature
- ❑ Power of Attorney
- ❑ Executor / Adm. Estate
- ❑ ASV knows individual
- ❑ Other, specify: _____