Authorization To Disclose Protected Health Information

The purpose for the use / disclosure of this information is:

- ❑ Patient / Personal Representative
- ❑ Physician Care
- ❑ Legal
- ❑ Insurance
- ❑ Other, Specify _____

3, 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.

4, 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 INTERNAL 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:_____