Authorization for Use and/or Disclosure of Protected Health Information

Patient Identification

Printed Name: _____ Date of Birth: _____
Address: _____
Email: _____
Social Security #* _____ Telephone: _____

Information To Be Released - Covering the Periods of Health Care

From (date)_____ to (date)_____
From (date)_____ to (date)_____

Please check type of information to be released:

☐ Entire medical record	☐ Pathology report	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results/reports	☐ X-ray reports	☐ X-ray films / images
☐ Operative report	☐ Emergency room record	☐ Itemized bill

☐ Other, (specify) _____

Purpose of Reques

☐ Treatment or consultation ☐ At the request of the patient ☐ Billing or claims payment
☐ Other, (specify) _____

Record DeliverV Method:

☐ Mail ☐ Paper Copy (pick up) ☐ Hospital location ☐ ER/Clinic location
☐ Email Link * **email link will be sent to email provided above***

Person Authorized to Receive Information ☐ **Same as the Patient Information**

Name: _____
Address: _____
Email: _____

Drug and/or Alcohol Abuse and/or PsVchiatric, and/or HIWAIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** ☐ Yes ☐ No _____ Initials

Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. **Check One:** ☐ Yes ☐ No _____ Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired

Time Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Ascension Sacred Heart Bay, 615 N Bonita Ave, Panama City, FL 32401. Unless revoked, this authorization will expire on the following date or event _____

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that Ascension Sacred Heart Bay may not condition my treatment on whether I sign this authorization form unless specified above under.Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I **authorize** _____ **to use and disclose the protected health inforTnation specified above.**
(Name of Facility or Provider)

Signature _____ Date: _____

Authority to Sign if not patient: _____

Identity of Requester Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

Verified by: _____

Ascension Sacred Heart

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Demographics
w/ barcode