AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name_____

Date of Birth_____ Health Record Number_____

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

2. The following individual or organization is authorized to make the disclosure:

_____

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ Most recent history and physical
- ☐ Most recent discharge summary
- ☐ Most recent operative/procedure reports
- ☐ Laboratory from (date)_____ to (date) _____
- ☐ x-ray and imaging reports from (date)_____ to (date) _____
- ☐ Consultation reports from (date)_____ to (date) _____
- ☐ Other_____

_____

4. I understand that the information in my health record may include information relation to behavior or mental health services, and treatment for alcohol and drug abuse, sexually transmitted diseases, AIDS, or HIV, but that information will not be released unless specified in #3 (other).

5. This information may be disclosed to and used by the following individual or organization:

Name:

Address:

For the purpose of:

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already has been released in response to this authorization. I understand 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 months.

7. 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 copy this information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential of un-authorized 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 (insert HIM director, privacy officer, or other office or individual's name or contact information.)

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness