

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____ Health Record Number: _____

1. I authorize the use or 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. This information may be disclosed to and used by the following individual or organization:

Address: _____

for the purpose of _____

4. This authorization permits the use and/or disclosure of the following information about the patient: (check all applicable boxes and initial selection as required)

_____ (Initial) All my health information pertaining to any medical history, physical condition and treatment received. Except: _____

-OR-

_____ (Initial) Only the following records or types of health information and/or on the specified dates:

Date(s) of Treatment: _____

Type of Treatment: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> EKG Results | <input type="checkbox"/> Medications |
| <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Consultation | <input type="checkbox"/> History |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Physicals | <input type="checkbox"/> Orders | <input type="checkbox"/> Emergency Records |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> All health information relating to above date(s) or type of treatment | | |
| <input type="checkbox"/> Other _____ | | |

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(Continued)

5. 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.
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 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 one year.
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, payment, enrollment or eligibility for benefits. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient