Health System

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional)_____

Date of Birth _____ Address _____

Phone Number (_____)_____Date of Service _____

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

1. _____ is authorized to make the disclosure.

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

- ☐ Facesheet
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Progress Notes
- ☐ Physician Orders
- ☐ Outpatient Record
- ☐ Emergency Dept. Record
- ☐ EKG Report
- ☐ EBC Application
- ☐ Autopsy Report
- ☐ Laboratory Results
- ☐ Imaging Results
- ☐ Bill / Claim Form
- ☐ Itemized Statement
- ☐ Other_____

Records Release Format
- ☐ e-delivery (Healthport Connect)
- ☐ CD
- ☐ Paper

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, 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.

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

   Name: _____

   Address: _____

5. For the purpose of _____

6. 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 Medical Record 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.

7. Unless otherwise revoked, the 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 from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper or electronic format.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
    or
    I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
    Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME