Patient Name:_____ Date of Birth:_____ MR#:_____
Address:_____Phone #:_____
City:_____ State:_____ Zip Code:_____

*To be completed by requester*: __ Pick Up __ Mail __ Other:_____ __ E-Mail:_____
If requested health information is needed for a doctor's appointment, please specify date: _____

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO RELEASE THE FOLLOWING
Name:_____Phone:_____
Address:_____Fax:_____
City:_____State:_____Zip Code:_____

Admission/ Discharge Date(s):_____
Forward to Health Information Management (Medical Records) for:
___ Discharge Summary
___ History & Physical
___ Consultation ___ Other (specify) _____
Forward to Patient Business Office for: ____ Billing information

_____

Reason for requesting information: _____
(Requests may be subject to copying fee)

THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDULA OR ORGANIZAION:
Name:_____Phone:_____
Address:_____Fax:_____
City:_____State:_____Zip Code:_____
Physician E-Mail:_____Patient E-Mail:_____

I understand that I have the 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 the 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 (not to exceed 90 days): _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date signed.

I understand that authorizing the release 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 released, as provided in CFR 164.524. I understand that any release of information carries with it the potential for an unauthorized re-release and the information may not be protected by Federal confidentiality rules. If I have questions about release of my health information, I can contact the authorized individual or organization making disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease, and all other sensitive information.

Patient Signature: _____ Date:_____

Authorized Representative/Parent:_____ Date:_____
Printed Name of Authorized Representative/Parent:_____
Relationship to Patient :_____
Address & Phone # of Authorized Representative/Parent:_____

AUTHORIZATION FOR USE AND/OR DISCLOSURE AND
REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT ID LABEL