Patient's Name: ______________________________ Date of Birth: ________________

Address: ______________________________ City ________________ State _____ Tel: ________________

I hereby authorize the use/ access/ disclosure of my protected health information as describe below:

**The following organization is authorized to make the disclosure:**

(Name of the Facility) ______________________________

Address______________________________ Tel: ________________ Fax: ________________

**This authorization is for the listed date(s) of treatment:** From: ________________ To: ________________

**Information to be released or disclosed (check all that apply):**

**An abstract of the medical records consist of history and physical, discharge summary, consultations, operative reports, x-rays, labs, EKG, Emergency room records and diagnostic studies.**

☐ Abstract of my medical record.
☐ Discharge Summary
☐ Consultation Reports
☐ Operative/ Cath Reports
☐ History & Physical

☐ Cardiology Images
☐ Radiology Reports
☐ Laboratory Results
☐ Immunization Record
☐ Other: ________________

**Behavioral Health Reports:**

☐ Social History
☐ Client Data Form
☐ Referral/Treatment Form
☐ Admission Evaluation
☐ Notification of Admission

☐ Treatment Plan
☐ Academic History
☐ Aftercare Instructions
☐ Psychological Evaluation
☐ Other: ________________

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 of alcohol/drug abuse.
The information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.
I understand that your facility may receive compensation for medical record copying in accordance with State law.

**This information may be disclosed to and used by the following individual/ organization:**

Name: ______________________________

Address: ______________________________ City ________________ State ______ Tel: ________________ Fax: ________________

**Information is to be:** ☐ Mailed to the above address ☐ Picked up by the above-named individual

**Reason for the disclosure:** ☐ Further medical care ☐ Legal action ☐ Personal ☐ Insurance ☐ Other: ________________

I understand I have the right to inspect and obtain a copy of my protected health information in my designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. section 263 (a), and certain other records.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described above.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

I understand that I may revoke this authorization in writing at any time. To 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 that the revocation will not apply to information that has already been released in response to this authorization. This authorization shall automatically expire 90 days from the date of the signature below unless otherwise specified.

______________________________ ______________________________ ________________
Signature of Patient Name of Patient (Printed) Date

______________________________ ______________________________ ________________
Legal Representative Relationship and Legal Authority Date

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

______________________________ ________________
Signature of Witness Date

**FOR DEPARTMENT USE ONLY**

Released by: ________________ Date: ________________

## AUTHORIZATION FOR RELEASE, USE, AND DISCLOSURE OF HEALTH INFORMATION

840-048i (10/2009)