AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ____ Date of Birth: _________________

Medical Record Number (MRN): ________________________

1. I authorize the use or disclosure of the above 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
- ❑ Procedure Report
- ❑ EKG reports from (date)_________ to (date)_________
- ❑ Laboratory reports from (date)_________ to (date)_________
- ❑ Pathology reports from (date)_________ to (date)_________
- ❑ X-ray and imaging reports from (date)_________ to (date)_________
- ❑ Consultation reports from doctors' names)_______________________________________
- ❑ Other (please specify)____

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4. 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.

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

____

Address: ____

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 health information management 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 insurers with the right to contest at 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 90 days.

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 the information to be used or disclosed as provided in CFR 164.524. I understand that 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.

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Signature of Patient or Legal Representative Date

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