AUTHORIZATION FORM FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

IDENTIFICATION OF THE PATIENT:

PATIENT NAME:_____ DATE OF BIRTH_____
SOCIAL SECURITY NUMBER OR OTHER IDENTIFIER_____

TYPE OF RECORDS/INFORMATION TO BE DISCLOSED: If you want both types of records disclosed you must use two separate forms – One for each purpose.

___ Records except for Psychotherapy Notes __ Psychotherapy Notes only

Face sheet	Physician Orders	Pharmacy Reports
Discharge Summary	Physician Notes	Nursing Notes
History and Physical	Laboratory Reports	Nursing Flow sheets
Emergency Room Record	Radiology Reports	Discharge Information
Clinic/Consultation	EKG	Social Services Notes
Operative Report	Respiratory Notes	Entire Record

For other or any information circled above please specify type and dates: (CT scan of head/ CBC/specific doctor consult etc.)_____
_____

Persons, facility, or class of persons who are authorized to use or disclose (provide) the records/ information:
_____

Persons, facility or class of persons who are authorized to receive the records/ information: (Name, address, fax number) :
_____
_____

Purpose for which information/records will be used or disclosed:

___ At the request of the patient
___ For sharing with other health care providers
___ Disability Determination
Other: (Please describe) :_____

Expiration: This Authorization will expire on:_____(MM/DD/YY) or on the following specific event:
_____

To be completed only if a health plan or health care provider has requested the authorization: Will the hospital receive financial or in-kind compensation in exchange for using or disclosing these records/ information: ___yes ___no.

Authorizing Signature:

- I understand that once the uses or disclosures have been made as permitted by this form the records/information may be subject to re-disclosure and no longer protected by federal privacy regulations.
- 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.
- I may inspect or receive a copy of any records/information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation to the Health Information Department.
- If I revoke this authorization it will have no effect on actions already taken on reliance on this form.
- If this information is at the request of the hospital for it's own use or disclosure I understand that I may refuse to sign this form. If I do not sign this form my health care or payment for health care will not be affected.
- I authorize the use or disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE DATE OF SIGNATURE

PERSONAL REPRESENTATIVE'S RELATIONSHIP TO PATIENT: _____