

Release of Information

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION:

Date:	Pt ID:	Acct #:
Last Name:	First:	MI:
Date of Birth: _____ Patient Address: _____ Patient Home Phone: _____	Requestor's Name: _____ Requestor's Address: _____ Requestor's Phone: _____ Requestor's Fax: _____	

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL: Date: _____

PURPOSE OF DISCLOSURE:

- Legal services
 Processing of my insurance claim
 Other: _____
- Treatment in the facility indicated above
 Application of insurance or state/federal funding programs

I specifically authorize the use and/or disclosure of the following highly confidential information: Mental health, HIV results, AIDS information, sexually transmitted diseases, alcohol or drug abuse, sexual assault and/or child/adult abuse and/or neglect. _____ (patient's signature)

SPECIFY INFORMATION TO BE DISCLOSED:

- History & Physical
 Pathology Report
 Consultation Report
- Operative Report
 X-Ray Reports
 X-Ray Films
- Lab Reports
 Other: _____

I UNDERSTAND THAT:

- λ I have the right to revoke this authorization for any reason and this revocation will not apply to information that has already been released in response to his authorization.
- λ If I revoke this authorization, I must do so in writing and present my written revocation to the health information management department.
- λ I can refuse to sign this authorization.
- λ Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- λ Authorizing the disclosure of my health information is voluntary.
- λ I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if requested.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED:

_____ Signature of Patient/ Guardian/ Representative	_____ Date
_____ Print name of Patient/ Guardian/ Representative	_____ Relation to Patient

FOR FEMALE PATIENTS ONLY:

For Mammography Breast Patients Only: I have been given an implant disclosure statement form. _____ (initial)
 As of today's date there is **NO** possibility that I may be pregnant. _____ (initial)
 Date of last menstrual cycle: ___/___/___

For Internal Use Only

- Records released by: Fax Mail Patient Other: _____
- Signature of staff releasing information: _____
- Validity of Requestor**
- Driver's license
 Passport
 Comparison of signatures documented in the PHI records
 Request faxed on requestor's letterhead