

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's PRINTED Name:		Birthdate:		Social Security No	
Address: City, State:		Home Phone Number:		Work Phone Number:	
I hereby authorize _____ (hospital) to disclose records obtained in the course of my evaluation and/or treatment to: (Name and address of person or organization to which disclosure is to be made)					
Name:		Address:			
Phone Number:		City:			
Phone Number:		Fax Number:			
Type of Access Requested: _____ Copies of Record OR _____ Inspection of records OR _____ Release to Media/Marketing Medical Records Requested: (Entire Record or Selected Portions of PHI as marked below) (recording, filming, interview, photo)					
Description: <input type="checkbox"/> Entire Records (or Portions): <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Room Records <input type="checkbox"/> History and Physical <input type="checkbox"/> Consult Report(s) <input type="checkbox"/> Operative Report(s) <input type="checkbox"/> Rehab Services Type: _____	Date(s)	Description: <input type="checkbox"/> Lab <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Record <input type="checkbox"/> Psychological Record <input type="checkbox"/> Psychiatric Record(s) <input type="checkbox"/> Progress Notes <input type="checkbox"/> Physician Orders <input type="checkbox"/> Pathology Report	Date(s)	Description: <input type="checkbox"/> Face Sheet <input type="checkbox"/> Cardiopulmonary Report <input type="checkbox"/> Immunization Information <input type="checkbox"/> Other _____ <input type="checkbox"/> Billing Records * <input type="checkbox"/> Detailed Bill <input type="checkbox"/> UB92 *Forward to the PAD for processing	Date(s)
_____(Initials) I DO <input type="checkbox"/> or I DO NOT <input type="checkbox"/> consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results, genetic information or such disclosure shall be limited to the following specific types of information: _____					
List the purpose(s) (including marketing) for the release or disclosure of Protected Health Information: _____					
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing the information? <input type="checkbox"/> Yes** <input type="checkbox"/> No **If yes, describe the type of compensation: _____					
<i>This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact the Hospital's Health Information Management/ Medical Records Department for assistance at () - .</i>					
This consent shall become invalid and expire 180 days from the date of signature, unless otherwise stated: Expiration date: _____ or Expiration Event: _____ None: _____, or define: _____					
I understand that: 1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization. 2. I have the right to receive a copy of this authorization. Copy of the authorization received. <input type="checkbox"/> _____(Initials) 3. A copy or facsimile (fax) of this authorization is as valid as the original. 4. My healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization.					
I hereby release _____ (hospital) from any and all legal liability and injuries that arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service and /or electronic facsimile in accordance with the hospital's facsimile (fax) policy.					
I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.					
SIGNED: _____		DATE: _____			
(Signature of Patient/Legal Guardian or Representative*) If signed by other than patient, indicate relationship: _____					
Witness: _____		DATE: _____			
*Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.					
To the Party Receiving this Information: This information has been disclosed to you from the records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise as permitted by such law and regulations. A general authorization for the release of such medical or other information is not sufficient for this purpose. Fees will be charged for the release of information in accordance with the law.					

OFFICE USE ONLY:

Complete by: _____ Date Completed: _____ Copy sent to PAD (date): _____

Medical Record #: _____ Acct. #: _____