AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: _____ Date of Birth: _____

Person(s)/organizations authorized to use/disclose information (from): _____

_____

_____

_____

Person(s)/organizations authorized to receive the information: _____

_____

_____

_____

Information that may be used/disclosed:
(Include dates where appropriate, e.g., medications dispensed in December 2002 or EKG Report performed in June 2000)

- ❑ Record of Visits (all) _____
- ❑ Record of Visit(s) (Specific) _____
- ❑ Discharge Summary _____
- ❑ History/Physical _____
- ❑ Consultation Report(s) _____
- ❑ Operative Report(s) _____
- ❑ Problem List _____
- ❑ Progress Notes _____
- ❑ Immunization Record(s) _____
- ❑ Medication Record(s) _____
- ❑ Laboratory Report(s) _____
- ❑ X-Ray, MRI, CT _____
- ❑ Echo, Stress Tests, Holters _____
- ❑ EKG Report _____
- ❑ Mental Health/Alcohol/Drug Abuse Treatment _____
- ❑ AIDS or HIV Information _____
- ❑ Hepatitis Information _____
- ❑ Entire Medical Record _____
- ❑ Statement of Charges/Payments _____
- ❑ Other _____

SECTION B: Must be completed only if a health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

   a. The information will be used/disclosed for the following purposes:

   - ❑ Continued Patient Care
   - ❑ Disability Determination
   - ❑ Personal Use
   - ❑ Attorney/Legal
   - ❑ Insurance Claim
   - ❑ Other _____

   b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

3. I understand that I may inspect and copy any information to be used or disclosed.

SECTION C: Must be completed for all authorizations.

1. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires _____
   (Insert applicable date or event that triggers expiration)

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

_____ _____
Signature of Patient or Representative Today's Date

_____ _____
Printed Name of Patient's Representative (if applicable) Relationship to Patient