Patient Authorization for Release of Medical Information

Patient's Name:	Date of Birth:	Social Security Number:
Address:	Telephone Number: ( )	

I hereby authorize employees, Medical Staff members or other agents of _____ _____(Facility Name) to use or disclose the following protect health information:

□ Copy of the Complete Record (s) □ Lab Reports □ History/Physical Examination
□ Progress Notes □ Discharge Summary □ Radiology Reports/Film (s)
□ Operative Report □ Pathology Reports □ Emergency Department Record (s)
□ Other as specified below: _____
_____

To be used by or released to:_____
_____

For the following purpose:
□ At the Request or Direction of the undersigned individual
□ For Marketing – This organization will/will not (cross out one) receive compensation, whether monetary or otherwise, as a result of the use or disclosure of your health information for marketing.
□ For Research (describe) _____
□ Other (describe)_____

*If this form authorizes the use or disclosure of psychotherapy notes, it may not be used to authorize the use or disclosure of any other Protected Health Information. A separate authorization is needed for any other use or disclosure.
*This authorization also includes any information in my medical records regarding diagnosis/treatment of alcohol/drug abuse, psychiatric or mental illness, immunodeficiency syndrome (AIDS) or tests for human immunodeficiency virus (HIV).

This Authorization expires:
□ On the following date: ___/___/_____
□ When the following event occurs:_____
□ No Expiration (permitted only for authorizations used to create or maintain research databases or repositories)
*Unless otherwise specified, this authorization will expire six (6) months from the date signed by patient or legal authorized agent, and covers only treatment prior to that date.

You may revoke this authorization at any time, in writing, except to the extent that we have already relied upon it in making a use of disclosure. If you are providing this authorization to obtain insurance coverage, you may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy.

If the only reason you have asked us to provide a health care service is so we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this authorization. Example – if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this authorization permitting us to disclose the results to your employer.

I understand this authorization is voluntary and that I may refuse to sign this authorization, and that my refusal will not affect my ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit except as stated above.

I understand that signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws.

_____ _____ _____ _____
Patient's Signature Date Witness Date

*The above individual is unable to consent because:
□ Minor □ Incompetent □Other (explain) _____

I hereby consent on behalf of the patient name on this authorization:

_____ _____ _____
Signature Date Relationship

_____ _____
Witness Date