AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION	**FOR INTERNAL USE ONLY** MR # ACCT # (most recent) ____________ Date Received ________ Date Completed ________ Completed By____________

I authorize the release of protected health information to be disclosed and used by the following:

TO (Receiving Facility)

Name: ____________

Address: ____________

City: ____________

State, Zip: ____________

Phone #: ____________

Fax #: ____________

FROM (Releasing Facility)

Name: ____________

Address: ____________

City: ____________

State, Zip: ____________

Phone #: ____________

Fax #: ____________

Patient Name

Date of Birth

Address

Social Security Number

Daytime Phone Number ____________

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows, including dates:

REPORT TYPE	DATE(S)	REPORT TYPE	DATE(S)
❑ Facesheet	________	❑ Progress Notes	________
❑ Discharge Summary	________	❑ Physician Orders	________
❑ History & Physical	________	❑ Lab Report	________
❑ Emergency Dept Record	________	❑ X-Ray Report	________
❑ Consultation Report	________	❑ Fetal Monitor Strip	________
❑ Operative Report	________	❑ Entire Record	________
❑ Anesthesia/Surgery Report	________	❑ Other, specify	________

3. 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.
4. The purpose for the use/disclosure of this information is:
   - ❑ Patient/Personal Representative
   - ❑ Physician Care
   - ❑ Legal
   - ❑ Insurance
   - ❑ Other, specify ____________

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department or Privacy Officer.

______________________________________ ______________________________

Signature of Patient or Legal Representative — Date

______________________________________ ______________________________

If signed by Legal Representative, Relationship to Patient — Signature of Witness

****

FOR INTERNAL USE ONLY

Identification of Patient or Personal Representative:

- ❑ Driver's License
- ❑ Work Photo Badge
- ❑ Other Photo ID
- ❑ Social Security Number
- ❑ Two Utility Bills
- ❑ Notarized Signature
- ❑ Power of Attorney
- ❑ Executor/Adm Estate
- ❑ StV Knows Individual
- ❑ Other, specify ______________________________________