

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION



## 1. Patient Information

Name – Last, First, MI	Former Name(s)/Alias		
Street Address	City	State	Zip
Medical Record Number (if known)	Date of Birth	Phone	

**I hereby Authorize:** Written/Electronic Communication Between 2 & 3.

Check "Yes" to also authorize Verbal Communication Between 2 & 3  Yes

## 2. Requesting Health Information Disclosure By:

## 3. Disclosed To: (Need FULL mailing address)

\_\_\_\_\_  
Name (i.e., Health Care Facility, Provider)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Name (i.e., Insurance Company, Lawyer, Provider)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

**4. Date(s) of Information to be Disclosed:** \_\_\_\_\_ to \_\_\_\_\_. If left blank, only information from the past two (2) years will be disclosed.

**5. Type of Information to Be Disclosed:**  Summary (last 2 years)  Records pertaining to condition(s): \_\_\_\_\_

Discharge Summary     History & Physical     Operative Report     Rehab Notes

Consultation Reports     Immunizations     Problem List     X-ray/Imaging Reports

ER Report     Laboratory/Pathology Reports     Progress Notes     All clinic records

Electrocardiogram Records     Medication List     Other (specify): \_\_\_\_\_

**6. State and Federal Laws require specific authorization prior to disclosing certain information. Please check if you would like any or all the following information disclosed:**

Mental/Behavioral health conditions     Drug/Alcohol Abuse/Treatment     Developmental Disability     HIV/AIDS

**7. Purpose or need for disclosure:**  Future Medical Care     Insurance Eligibility/Benefits     Personal

Workers' Compensation     Legal Investigation/Law Enforcement     Disability Determination

Other: \_\_\_\_\_

**8. Expiration Date:** This authorization will expire on \_\_\_\_\_, or  after the above information has been released. If I do not indicate a date, this will expire one (1) year from the date of my signature below. This authorization covers records that were created or existing, on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until expiration date.

**Your Rights with Respect to This Authorization**

**Right to inspect or copy the health information to be used or disclosed** - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect or obtain copies of my health information by contacting the Health Information Department.

**Right to receive copy of this authorization** - I understand that if I agree to sign this authorization, I will be provided with a copy of it.

**Right to refuse to sign this authorization** - I understand that I am under no obligation to sign this form and that Mile Bluff Medical Center may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits on my decision to sign this authorization (exception: to provide care that is done solely for the purpose of creating protected health information for release to another party, in which case care cannot be provided without authorizing disclosure). Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services.

**Right to withdraw this authorization** - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the Health Information Department. I am aware that my withdrawal will not be effective until received and will not be effective regarding the uses and/or disclosures of my health information that the person(s) and/or organization(s) listed here have made prior to receipt of my withdrawal statement. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy or the policy itself.

**HIV test results** - I understand my HIV test results may be released without authorization to persons/organizations that have access under State law, and that a list of those persons/organizations is available upon request.

**REDISCLASURE NOTICE:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. (If you are signing as a parent of the minor patient listed above, you are declaring that you have parental rights and physical placement of the child.)

**Signature of Patient/Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name of Person Signing:** \_\_\_\_\_

**Signature of Minor (Age 14-17) Behavioral Health ONLY:** \_\_\_\_\_

**Indicate Relationship (if signing on behalf of the patient):**

- Custodial Parent    Court Appointed Guardian    Next of Kin    Personal Representative    Health Care Agent
- Other: \_\_\_\_\_

<b>For Organizational Use Only</b>				
Date Received:	Date & Time Released:	<input type="checkbox"/> Mailed	<input type="checkbox"/> Faxed	<input type="checkbox"/> Picked Up By:

Revised: 10/08; 2/11; 5/11; 11/11; 6/13; 3/14; 1/18; 3/19; 2/26