AUTHORIZATION FOR RELEASE OF INFORMATION

❑ Verbal Authorization ONLY ❑ Floor Staff to Complete Request Prior to Discharge ❑ HIM to Complete Request Post Discharge

Name of Patient ______________________ Birthdate __________ Medical Record Number: __________

I hereby authorize ____
(Name of Individual or Organization)

to release to ____
(Name of Individual or Organization to Receive Information) Contact #

the following information from my medical record for the time period: ______________________________ .

By: ❑ Fax # ________________ ❑ Mail ______________________________ ❑ Hand Carry
(Address)

____ Clinical Resume/Discharge Summary
____ History and Physical Report
____ Consultation Report
____ Operative Report
____ Emergency Room Record

____ Pathology Report
____ Laboratory Report
____ Radiology Report
____ EKG Report
____ Billing Records

____ Other (Please specify below)
____
____

Request Complete ❑
Associate Initials______ Date______ Time_____
Pages Sent _________

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records:

❑ Psychiatric/Psychological __________ (Initials) ❑ HIV __________ (Initials) ❑ Drug And/or Alcohol Dependency __________ (Initials)

The information is necessary for the following purpose:

____ Diagnosis and Treatment ____ Legal ____ Personal: ______________________
____ Insurance Billing ____ Military ____ Other: ______________________

This authorization shall remain in effect until the following date, event, or condition: ______________________
If no date, event, or condition is specified, this authorization will expire in one year.

1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

______________________________ (Signature of Patient or Legal Representative)
____________________ (Relationship)
______________ (Date)

❑ Photo ID checked by: ____________________
OR
❑ Signature verified by: ____________________

____
(If patient is unable to sign, state reason.)

❑ **CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING CHEMICAL DEPENDENCY RECORDS**
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibits you from making any further disclosure of it without the specified written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose.

CHI St. Alexius Health

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