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AUTHORIAZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

□ **Access request to Copy/Inspect**

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

   _____
   Name of Facility

   _____
   Address

2. The type of information to be used or disclosed is as follows (please include dates of service):
   Dates of Service: _____

□ Complete Medical Record	□ Discharge Summary
□ Abstract of Medical Record	□ X-ray & Imaging Reports
- H&P	□ Operative Reports
- Discharge Summary	□ Progress Notes
- Consultation Notes	□ Laboratory Test Results
- Operative & Procedure Reports	
- EKGs	□ Immunization Records
- Labs	□ History & Physical
- X-ray & Imaging Reports	□ Other: _____

Behavioral Health Reports

□ Social History	□ Treatment Plan
□ Client Data Form	□ Academic History
□ Referral/Treatment Form	□ Aftercare Instructions
□ Admission Evaluation	□ Psychological Evaluation
□ Notification of Admission	□ Other: _____

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse.

4. I understand that your facility may receive compensation for medical record copying in accordance with State Law.

5. This information may be disclosed to and used by the following individual/organization:
   Name: _____

   Address: _____

For the purpose of:

□ Future Medical Care
□ Inspection/Copying of my Records
□ Personal
□ Other: _____
□ Insurance Eligibility
□ Legal Investigation or Action
□ Changing Physicians

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceedings, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C Section 263 (a)), and certain other records.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described above.
8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.
9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and resent my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has been released in response to this authorization. This authorization expires within 90 days, unless otherwise specified.

_____ _____
Signature of Patient (State relationship if not patient) Date

_____
Name (Please Print)

Patient Is: □ Minor □ Incompetent □ Disabled □ Deceased
Legal Authority: □ Custodial Parent □ Legal Guardian □ Executor of Estate (Deceased)
□ Power of Attorney □ Authorized Legal Personal representative

_____ _____
Signature of Witness Date