



AUTHORIZATION TO DISCLOSE CONFIDENTIAL HEALTH INFORMATION

Patient Name:		Date of Birth:
Patient Address:		
City:	State:	Zip Code:
Best Contact Phone:		Cell / Other Phone:
Describe what specific records may be disclosed / check all that apply: <input type="checkbox"/> Records from (date) _____ to (date) _____ <input type="checkbox"/> Billing Records, detail bill <input type="checkbox"/> Lab / diagnostic / test results only <input type="checkbox"/> Nursing Notes, documentation <input type="checkbox"/> Imaging / Radiology Reports <input type="checkbox"/> Operative or Procedure Notes <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Physician notes, orders, history & physical <input type="checkbox"/> Other records / please specify: _____		
Purpose of Disclosure: <input type="checkbox"/> Personal <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Other (specify): _____		
Format: <input type="checkbox"/> Electronic <input type="checkbox"/> Media <input type="checkbox"/> Paper copies <input type="checkbox"/> Inspect or review medical record		
Delivery Instructions: <input type="checkbox"/> Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> *Email: _____		
*(If you want to receive your protected health information via email, it will be sent unencrypted. NOTE: UNENCRYPTED EMAIL MAY BE AT RISK FOR INADVERTENT DISCLOSURE. BY PROVIDING YOUR EMAIL ADDRESS, YOU ACCEPT THIS RISK.)		

I authorize disclosure of the above listed information to the following organization or individual:

SELF (the patient would like their records)

INDIVIDUAL / FACILITY:

Name: _____			
Address: _____		Phone: _____	Fax: _____
City: _____		State: _____	Zip: _____
Please complete more than one form if multiple disclosures to multiple providers is requested.			

- I understand and acknowledge that the requested health information to disclose may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/ AIDS related conditions, sexually transmitted diseases, and/or alcohol/drug abuse. This authorization does not include disclosure of Psychotherapy notes or Substance Abuse Disorder notes.
- This authorization will expire one year from date signed. I understand and acknowledge that I have the right to revoke this authorization at any time. I understand I must do so in writing via mail, email or faxing to the location the authorization was submitted to. This does not apply to information that has already been disclosed. This does not apply to Treatment, Operations or Payment disclosures to insurance companies when the law gives the insurers to contest a claim under policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. Research participation requires separate authorization by the patient. I understand that I may inspect or copy the information to be used or disclosed as provided by the federal government's rules, which are state in the United States Code of Federal Regulations at section 164.524.
- If I have questions about disclosure of my health information, I can contact Medical Records Department where the request was submitted to.
- I understand if I am requesting my information while I am In House/Admitted or receiving on-going services, my record may not be complete, and I will need to request after services are completed and finalized. Records provided will be for treatment on the date of signature and/or Prior to signature date.
- There may be a charge for copies of records.

I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

 Signature of Patient or Personal Representative Date Time Relationship of Personal Representative

For Facility's Use

Request for Access Received: _____

If patient or personal representative unable to complete form, please provide the name of the facility staff member who completed the form: _____.

Date Access Provided: _____

On-site: _____

Email: _____

Paper: _____

Other electronic media: _____

Signature of Privacy Officer/Designee

Date