



Site: \_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

1) Patient Information: \_\_\_\_\_  
Name of Patient / Previous Name

Date of Birth \_\_\_\_\_ ( ) \_\_\_\_\_  
Area Code / Telephone Number

Address \_\_\_\_\_ City / State / Zip \_\_\_\_\_

2) Persons / Organizations Authorized to Disclose Patient's Health Information:

3) Persons / Organizations Authorized to Receive Patient's Health Information:  Self; or

Name of Health Care Provider / Plan / Other \_\_\_\_\_

Name of Health Care Provider / Plan / Other \_\_\_\_\_

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

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

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

4) Delivery Options:  Mail  View On-Site  Other \_\_\_\_\_  
 Hand Carry / Pick-Up (Date & Time) \_\_\_\_\_  
 Authorized Person to Pick-Up Health Information \_\_\_\_\_

5) Health Information to be Disclosed: (Check applicable information)

Hospital Abstract  Clinic Abstract  Behavioral Health Abstract  VNA Abstract

(A detailed description of these abstracts is located on the back of this Authorization.)

Laboratory Reports (Specify Test) \_\_\_\_\_

Radiology Reports (Specify Test) \_\_\_\_\_

Radiology Films (Specify Test) \_\_\_\_\_

Billing Records \_\_\_\_\_

Pathology Slides (Specify Test or Procedure) \_\_\_\_\_

Other \_\_\_\_\_

For the following date(s) \_\_\_\_\_

I DO NOT WANT THE FOLLOWING HEALTH INFORMATION DISCLOSED: (Check applicable information)

Human Immunodeficiency Virus (HIV) Test Results  Developmental Disability Records

Mental Health Records  Alcohol and Drug Abuse Records

6) Purpose for Need of Disclosure: (Check applicable categories)

Further Medical Care  Legal Investigations  At the Request of the Individual

Insurance Eligibility / Benefits  Other: \_\_\_\_\_

7) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION ARE SET FORTH ON THE BACK OF THIS AUTHORIZATION.

8) Expiration Date: This Authorization is good until the following date(s) / event \_\_\_\_\_

If no date or event is specified, this Authorization will expire one (1) year from the date signed.

**REDISCLASURE NOTICE:** I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this Authorization may be redisclosed by the recipient and no longer be protected by such laws.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

9) Signature of Patient/Legal Rep: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship or Authority to Act for the Patient \_\_\_\_\_

(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement of the child because such placement would endanger the child's physical, mental, or emotional health.)

10) Witness (when applicable): \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

For Office Use Only: Records Picked Up by: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Films Picked Up by: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Slides Picked Up by: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



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- 5) **HEALTH INFORMATION TO BE DISCLOSED:** You are not obligated to authorize a disclosure of your / the patient's health information. You may authorize disclosure of as much or as little of your / the patient's health information as you wish.

**An abstract of health information MAY include:**

**Hospital Abstract:** History & Physical, Consultations, Operative Reports, Laboratory Reports, Radiology Reports, Emergency Room Reports, if applicable, Discharge Summary;

**Clinic Abstract:** Medical History, Progress Notes, Consultations, Laboratory Reports, Radiology Reports, EKG, Pathology Reports, Procedure Reports, Immunizations, Medication List, Therapy Evaluations and Notes;

**Behavioral Health Abstract:** History & Physical, Intake Assessment, Psych Evaluation, Laboratory Reports, Discharge Summary; and/or

**VNA Abstract:** Intake Referral, Skilled Discipline (i.e., RN, PT, OT, ST & MSW) Assessment and Notes, Medication Lists, Discharge Summary.

7) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Inspect or Copy the Health Information to be Used or Disclosed for this Authorization:**

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization.

**Right to Receive Copy of This Authorization:** I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of this Authorization.

**Right to Refuse to Sign This Authorization:** I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

**Right to Revoke This Authorization:** I understand that written notification must be presented to the Medical Records Department to cancel this Authorization. I understand that my withdrawal will not be effective as to uses and/or disclosures of my/the patient's health information (i) already made in reliance on this Authorization by the person(s) and or organization(s) listed in Section 2 and 3 of this Authorization or (ii) if this Authorization was obtained as a condition of obtaining insurance coverage, to the extent that such person(s) and/or organization(s) have the right to contest a claim under the policy pursuant to which such coverage is provided, or the policy itself.