HSHS Medical Group

Authorization for Release of Confidential Health Information

I hereby authorize:

_____

Name of Physician or Health Care Provider *Street Address* *City* *State* *Zip Code*

To furnish to:

_____

Name of Requestor *Street Address* *City* *State* *Zip Code*

The following information contained in the patient record of:

_____

Patient's Name *Date of Birth* *Street Address* *City* *State* *Zip Code*

Yes No

❑ ❑ The entire medical record, excluding mental health information, alcoholism and drug abuse information, and HIV/Acquired Immune Deficiency Syndrome (AIDS) records

To be disclosed, the following items must be specifically checked:

Yes	No		Yes	No	
❑	❑	Mental Health Records	❑	❑	Immunization Record
❑	❑	Alcoholism Records	❑	❑	Laboratory Reports
❑	❑	Drug Abuse Records	❑	❑	X-Ray Reports
❑	❑	HIV/Acquired Immune Deficiency Syndrome (AIDS) records	❑	❑	Operative Notes
❑	❑	Workers Compensation	❑	❑	Other: _____
❑	❑	Office Visit Notes			

The above information for the following period of time shall be released: From_____ to _____
(Date) *(Date)*

The purpose(s) of the authorization is (are):

_____

_____

(Specify e.g. continued treatment, payment for treatment, request by patient or legal representative, etc.)

- In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may be no longer protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied in it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written notification, this Authorization for Release of Confidential Health Information will automatically terminate 60 days from the date signed unless otherwise specified.

_____

Specify

_____

Signature of Patient or Legal Representative *Date* *(If you are not the patient, specify your relationship to the patient)*

_____

Witness

For Office Use Only: Date Received:_____ Date Sent:_____Initials:_____

❑ No charge - Referral/consult ❑ No charge - Request fullfilled internally totalling < 5 pages