

Patient Authorization for Disclosure of Health Information to Outside Facilities

Patient name: _____ Date of Birth: __/__/____

Last 4 digits of Social Security Number: _____

I request that my protected health information (PHI) be disclosed to:

Facility Name: _____

Address: _____

City: _____ State: __ Zip: _____ Phone: _____ Fax: _____

I authorize the following PHI to be released from my medical record(s): _____

Images and Reports covering the period of healthcare from: Specific Dates: _____ to _____

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

Purpose for requesting information: Continuation of Care

Disclosure format: US mail and/or Fax (healthcare provider only)

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire (time frame) _____ from date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sing this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient or Authorized Representative Signature

Date

Print Name and Relationship to Patient (if applicable)