Authorization for Release of Protected Health Information

I hereby authorize __________________________ to release information of ____

Facility/Person — Patient Name — Date of Birth

as described below to: ____

Facility/Person

______________________________________, ___________________________, ___________________________________

Address — Phone — Fax

Records are requested for the purpose of: ____

Records being requested are of the following description for the dates of: ______________________________ (if applicable)

_____ Inpatient Records ______ Outpatient Records ______ ER Records ______ Physician Dictation _____ H&P

_____ Discharge Summary ______ Operative Report ______ Pathology ______ Radiology _____ Physician Order

_____ Lab Report/Tests ______ Consults ______ Medications ______ Mammography

Other ____

All Records contained within these dates will be released unless otherwise specified __________________________________

Patient acknowledges the following:

- That my health records will not be released or obtained by Center for Digestive Health & Nutrition and/or Three Rivers Endoscopy Center unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information
- That the release of my health records will be for the purpose stated on this form
- The health records may be re-disclosed by the receiving Facility/Person and that 1) its staff/employees have no responsibility or liability as a result of the re-disclosure and 2) such information would no longer be protected by the Privacy Rule
- This authorization is in effect for 90 days from the dated signature
- I may revoke this authorization at any time by sending a written request where authorization was permitted but does not apply to any information that was already released prior to the date of the release to revoke the authorization, and that revoking the authorization may result in my insurance company not being able to pay for the medical service and I may be liable for the payment of the claim
- I am entitled to a copy of this completed authorization form as will be filed in my chart
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure
- I authorize release of HIV, Behavioral Health, and/or Drug & Alcohol ________ /pt initial.

____

PATIENT SIGNATURE — DATE

____

LEGAL REPRESENTATIVE — DATE — RELATIONSHIP TO PATIENT

Oral Authorization: I authorized that the person understood the nature of the release and freely gave his/her oral authorization. (2 witnesses)

____, Witness _______________________________________ Date

____, Witness _______________________________________ Date

☐ Copy provided to patient — Signature ____

Original filed in patient chart

Note: A copy or facsimile is acceptable in lieu of the original.

10/10