

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

<b>PATIENT NAME:</b>		<b>DATE OF BIRTH:</b>	
<b>PHONE NUMBER:</b>		<b>MR or VISIT NUMBER:</b>	
<b>STREET ADDRESS:</b>		<b>CITY, STATE ZIP</b>	
<b>INFORMATION BEING SENT TO/FROM (CHECK ONLY ONE)</b>	<input type="checkbox"/> Information to be released <b>FROM</b> Van Diest Medical Center <b>TO</b> the facility or individual specified below:  Name of facility or individual _____  Address _____  Phone _____	<input type="checkbox"/> Information to be released <b>TO</b> Van Diest Medical Center <b>FROM</b> the facility or individual specified below:  Name of facility or individual _____  Address _____  Phone _____	
	<b>PURPOSE FOR DISCLOSURE</b> <input type="checkbox"/> Treatment/Continued Care <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Personal Use <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Legal Review/Purposes <input type="checkbox"/> Other: _____		
<b>TYPE OF INFORMATION REQUESTED</b> <small>Please note: There may be a charge associated with copies of the Medical Record</small>	<b>For Date(s) of service:</b> _____		
	<input type="checkbox"/> Clinic Notes <input type="checkbox"/> Phys./Occ./Sp. Therapy <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Billing Information <input type="checkbox"/> Hospital Notes <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medications/Allergies <input type="checkbox"/> Immunization Records <input type="checkbox"/> EKG/Cardio/Echo      _____		
<b>SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION FURTHER PROTECTED BY STATE OR FEDERAL LAW</b>	<b>Initial here for any category to BE released:</b> _____ <input type="checkbox"/> AIDS-Related Information, Diagnosis, and Test Results <input type="checkbox"/> Substance Abuse (Drug or Alcohol) Information <input type="checkbox"/> Mental Health Information <input type="checkbox"/> Genetic Information		
	<p><b>** Federal and/or State law specifically requires that any disclosure or re-disclosure of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:</b>          This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.</p>		
<b>DISCLOSURE:</b>	<p>I understand that I may cancel (revoke) this authorization at any time by sending a written notice to Van Diest Medical Center's HIM/Medical Records department and that my cancellation will take effect when the written notice is received and it will not apply to information that has already been released in response to this authorization. <b>This authorization will automatically expire <u>one year</u> from the date of signature except as specified.</b></p> <p>Specify expiration date, event, or condition _____</p> <p>I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by federal privacy regulations unless otherwise prohibited from re-disclosure under other federal and/or state laws or regulations.</p>		
<b>SIGNATURE AND DATE</b>  If this release is signed by a representative on behalf of the patient, complete the following:	Patient's Signature: _____ Date: _____ <b>OR:</b> Representative's Name: _____ Date: _____ Relationship to Patient: _____		
	<b>FOR OFFICE USE ONLY</b>  <b>Please do not write in this section</b>		
Request Received Date: _____ Records Released Date: _____ Released By: _____ Comments/ID: _____			