

ROI completed by: _____

Date completed: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

TO: _____

Patient Name: _____
DOB: _____ Record # _____

I authorize _____ to release my protected health information to:

Name/Title: _____

Organization _____

Address _____

City/State/Zip _____

The information is to be released for the following purpose:

Continuing Care Litigation Insurance Claim Other (specify) _____

At the request of the individual (check when patient elects not to disclose purpose)

Specific protected health information to be released from my medical record to include:

History & Physical Discharge Summary Operative Report

Pathology Report Consultation Report Laboratory Report

X-ray Report Progress notes other (specify) _____

Entire record **Electronic Health Record Requested- date requested _____

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

Indicate the time periods (dates) for which these records are being released:

From _____ to _____

I understand I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____. **If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date I signed it.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer.

Signature of patient/personal representative Date _____ Time _____

Relationship if signed by personal representative

Witness Date _____ Time _____