

AUTHORIZATION FOR RELEASE OF INFORMATION



Name of Patient _____ Birthdate _____ Medical Record Number: _____

I hereby authorize _____
(Name of Individual or Organization)

to release to _____
(Name of Individual or Organization to Receive Information) Contact # _____

the following information from my medical record for the time period: _____

By: Fax # _____ Mail _____ Hand Carry _____
(Address)

- | | | |
|--|--|--|
| <input type="checkbox"/> Clinical Resume/Discharge Summary | <input type="checkbox"/> Pathology Report | For Internal Use by St. Alexius Staff Completed By:

_____ Other (Please specify below)

_____ |
| <input type="checkbox"/> History and Physical Report | <input type="checkbox"/> Laboratory Report | |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Radiology Report | |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> EKG Report | |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Billing Records | |
| | | |

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records:

- Psychiatric/Psychological _____ Initials HIV _____ Initials Drug And/or Alcohol Dependency _____ Initials

The information is necessary for the following purpose:

- Diagnosis and Treatment Legal Personal: _____
 Insurance/Billing Military Other: _____

This authorization shall remain in effect until the following date, event, or condition: _____
If no date, event, or condition is specified, this authorization will expire in one year.

- This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
- I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
- I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations.
- A photocopy of this authorization is as effective as the original.

(Signature of Patient or Legal Representative)

(Relationship)

(Date)

- Photo ID Checked by: _____
 OR
 Signature Verified by: _____

(If patient unable to sign, state reason.)

CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING CHEMICAL DEPENDENCY RECORDS

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibits you from making any further disclosure of it without the specified written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose.

