

DATE RECEIVED: \_\_\_\_\_ Medical Record #: \_\_\_\_\_ Encounter #: \_\_\_\_\_

DATE STARTED: \_\_\_\_\_

AUTHORIZATION EXPIRATION DATE: \_\_\_\_\_ (see last paragraph below)

1. FROM:  Health Center  Home Care  Home Medical Equipment  
 Physician Clinic: \_\_\_\_\_  Hospice  Other: \_\_\_\_\_  
 SBL Dental Services

2. You are hereby authorized to release protected health information to: *(Who the protected health information is going to)*

\_\_\_\_\_  
 (Name of Party to Receive Protected Health Information)

\_\_\_\_\_  
 (Address) (City) (State) (Zip Code)

3. Release protected health information of: \_\_\_\_\_  
 (Name of Patient) (Birthdate)

\_\_\_\_\_  
 (Address) (City) (State) (Zip Code)

4. The patient or authorized representative authorizes the use or disclosure of protected health information to be released. **Patient or authorized representative must initial the item, which needs additional protected health information disclosed.**

- Abuse  Genetic Testing  Mental Health/Psychiatric  
 Alcohol and/or Drug Related  HIV/AIDS  Other: \_\_\_\_\_  Reproductive Health

5. Date(s) of Care: from: \_\_\_\_\_ to: \_\_\_\_\_

6. The Type of protected health information to be used or disclosed is as follows:

- Diagnosis / Procedures  Provider Progress Notes  Entire Admission  Imaging Reports  EKG Reports  
 History & Physical  Discharge Summary  Emergency Room Record  Imaging Films  
 Operative Report  Pertinent Data  Pathology Report  Lab Reports  
 Other (Specify) \_\_\_\_\_

7. Method of release:  Photocopies  FAX  CD  Film  Encrypted Email \_\_\_\_\_

8. For the purpose of:  Continued Treatment  Legal  Personal  Other \_\_\_\_\_

The foregoing authorization was read, discussed, and signed in my presence. I am signing freely and with full knowledge and understanding. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that other health care provider records may be a part of my hospital record and I can release them as authorized. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by the Federal Health Information Privacy Regulations. The redisclosure of drug and alcohol abuse is generally prohibited in accordance with the confidentiality of alcohol and drug abuse patient record rules. I understand that I can contact these departments for questions about disclosures of my protected health information.

I further understand that a refusal to authorize the release of the above information will prevent the disclosure of the information without further authorization or when mandated by law. There is the right to revoke the authorization in writing at any time. I understand that 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 when the law provides the insured with the right to contest a claim under my policy. **Unless otherwise revoked in writing, this authorization will expire 1 year from date signed.**

9. Signed \_\_\_\_\_ Date / Time \_\_\_\_\_  
 (Patient or Legal Representative)

If Legal Representative, document relationship to Patient: \_\_\_\_\_

Signed \_\_\_\_\_ Date / Time \_\_\_\_\_  
 (Witness)

For Office Use Only Processed By: \_\_\_\_\_ Date: \_\_\_\_\_ Number of pages: \_\_\_\_\_

