AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Holy Family Memorial

Sponsored by the Franciscan Sisters of Christian Charity

1) **PATIENT INFORMATION:** MRN / Chart #- _____

Name | Address | City | State | Zip

Date of Birth | Phone Number | Previous Name

2) **AUTHORIZES:**

Name of Health Care Provider / Plan / Other

Address

3) **TO DISCLOSE TO:**

☐ Self, Delivery Options: ☐ Pick up: ☐ View on Site ☐ Mail to address above

☐ To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to: ☐ _____

Name of Health Care Provider / Plan / Other

Address | Or Health Care Provider FAX #

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ (month/year) to _____ (month/year) **If left blank, only the past (2) yrs will be disclosed.**

5) **INFORMATION TO BE RELEASED:**

☐ X-ray Images ☐ Billing

☐ Hospital Records

To Include: History & Physical, Discharge Summary, Operative/Procedure, Consultation, Pathology, Lab & Diagnostic Tests.

☐ Clinic Records

To Include: Clinic Office Visit Notes, Lab & Diagnostic Tests.

☐ Other _____

I **WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):**

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health / Developmental Disabilities

6) **EXPIRATION:** This Authorization is good until the following date / event: _____

Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE** (Check all that apply - **copy fees may apply)** ☐ Further Medical Care ☐ Legal Investigation /Action

☐ Relocation ☐ Second Opinion ☐ Insurance Network Change ☐ Transfer of Primary Care

☐ Insurance Eligibility/Benefits ☐ Personal (at my request) ☐ **Other:** _____

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I understand that I have a right to inspect and receive a copy of the material to be disclosed (subject to usual copying charges). I understand that written notification is necessary to revoke this authorization, except to the extent that information may have been released before receipt of this notice. My decision to sign this authorization will not affect my treatment. If this information is being disclosed to an individual or entity that is not a health care provider or health plan, it may be subject to re-disclosure and no loner protected. A photocopy/facsimile of this form is valid as the original.

9) SIGNATURE OF PATIENT / LEGAL REP: _____ **DATE:** _____

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin / executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only: **Signature/ID verified** ☐Yes ☐No Completed by: _____ *Name / Date* # of pages released _____