

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION * Required Fields

Section A: * Must be completed for all authorizations

PATIENT IDENTIFICATION: _____
 Account Number _____ First Middle Maiden/Former Last
 Date of Birth _____ Social Security # XXX-XX-_____
 Phone # _____ Medical Record # _____

SPECIFIC INFORMATION NEEDED: **see information on back

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Abstract** | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Consults |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> HIV / AIDS (_____ initials*) | <input type="checkbox"/> Prenatal Records | <input type="checkbox"/> Clinic Notes |
| <input type="checkbox"/> Electrocardiogram | <input type="checkbox"/> Lab Report | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Financials |
| <input type="checkbox"/> Emergency Dept Records | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Psych Records (_____ initials*) | |
| <input type="checkbox"/> Photographs, videotapes, digital or other images | <input type="checkbox"/> Information regarding treatment of substance abuse (_____ initials*) | | |
| <input type="checkbox"/> Other (Please specify) _____ | | | |

PURPOSE:* Disclosure of this information is needed for...

- | | | |
|---|---|--|
| <input type="checkbox"/> Continuity of Medical Care | <input type="checkbox"/> Insurance Processing | <input type="checkbox"/> Legal Proceedings |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other (Please specify) _____ | |

AUTHORIZATION:* I authorize and request _____ to release medical information to _____ concerning my treatment to cover the period from _____ to _____

Section B: * Must be completed only if a health plan or a health care provider has requested this authorization

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

Section C: * Must be completed for all authorizations

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials* _____
 I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I will be given a copy of this authorization form, after signing. Initials* _____

Section D: * Must be completed for all authorizations

I hereby authorize the use or disclosure of my personal health information as described above. I understand that I may refuse to sign this authorization and that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying The Medical Records Department in writing and that this will automatically **expire on** ____/____/____* (MM/DD/YY) or 1 year from the date signed below, whichever is earlier. This hereby releases the sender from all legal responsibility or liability of the release of information described above from the records. I also understand that if I revoke my authorization it will not have any effect on any actions PMH took before it received the revocation. I understand that medical records, laboratory reports, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

Printed Name:* _____
(Patient or Authorized Representative)

Date:* _____

Signature:* _____
(Patient or Authorized Representative)*

Witness:* _____

(Relationship if other than Patient)*

Form of identification* Drivers License State issued ID Military ID Other _____

PLEASE SEND THIS INFORMATION TO THE ATTENTION OF:	SENDERS INFORMATION (PMH STAFF ONLY)
	Fax to: _____
	Number: _____
	Address: _____
	By Whom: _____
	Date Sent: _____

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
THIS FORM PART OF PERMANENT MEDICAL RECORD**



0153

DEFINITIONS REGARDING RELEASE OF INFORMATION

An abstract includes summary of typed reports as listed below. This is not an all inclusive listing.

Discharge Summary	Special Testing (ie: echocardiogram)
History & Physical	EKG
Consults	Emergency Dept. Physician Record
Operative Reports	
Pathology Reports	
Laboratory Reports	
Radiology Reports	

Authorized Representative: is a guardian, parent, or healthcare agent. Example: Legal Documents that support the release of medical information to an authorized representative are:

- Healthcare Power of Attorney
- Power of Attorney
- Marriage License
- Death Certificate
- Executor of estate documents

Financials may include but are not limited to:

- Billing Claims Information
- Itemized Statement

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION * Required Fields

Section A: * Must be completed for all authorizations

PATIENT IDENTIFICATION: _____
 Account Number _____ First Middle Maiden/Former Last
 Date of Birth _____ Social Security # XXX-XX-_____
 Phone # _____ Medical Record # _____

SPECIFIC INFORMATION NEEDED: **see information on back

<input type="checkbox"/> Abstract**	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Consults
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> HIV / AIDS (_____ initials*)	<input type="checkbox"/> Prenatal Records	<input type="checkbox"/> Clinic Notes
<input type="checkbox"/> Electrocardiogram	<input type="checkbox"/> Lab Report	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Financials
<input type="checkbox"/> Emergency Dept Records	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Psych Records (_____ initials*)	
<input type="checkbox"/> Photographs, videotapes, digital or other images	<input type="checkbox"/> Information regarding treatment of substance abuse (_____ initials*)		
<input type="checkbox"/> Other (Please specify) _____			

PURPOSE:* Disclosure of this information is needed for...

Continuity of Medical Care Insurance Processing Legal Proceedings
 Personal Use Other (Please specify) _____

AUTHORIZATION:* I authorize and request _____ to release medical information to _____ concerning my treatment to cover the period from _____ to _____

Section B: * Must be completed only if a health plan or a health care provider has requested this authorization

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

Section C: * Must be completed for all authorizations

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials* _____
 I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I will be given a copy of this authorization form, after signing. Initials* _____

Section D: * Must be completed for all authorizations

I hereby authorize the use or disclosure of my personal health information as described above. I understand that I may refuse to sign this authorization and that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying The Medical Records Department in writing and that this will automatically expire on ____/____/____* (MM/DD/YY) or 1 year from the date signed below, whichever is earlier. This hereby releases the sender from all legal responsibility or liability of the release of information described above from the records. I also understand that if I revoke my authorization it will not have any effect on any actions PMH took before it received the revocation. I understand that medical records, laboratory reports, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

Printed Name:* _____
 (Patient or Authorized Representative)

Date:* _____

Signature:* _____
 (Patient or Authorized Representative)*

Witness:* _____

 (Relationship if other than Patient)*

Form of identification* Drivers License State issued ID Military ID Other _____

PLEASE SEND THIS INFORMATION TO THE ATTENTION OF:	SENDERS INFORMATION (PMH STAFF ONLY)
	Fax to: _____
	Number: _____
	Address: _____
	By Whom: _____
	Date Sent: _____

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION
THIS FORM PART OF PERMANENT MEDICAL RECORD**



0153

DEFINITIONS REGARDING RELEASE OF INFORMATION

An abstract includes summary of typed reports as listed below. This is not an all inclusive listing.

Discharge Summary	Special Testing (ie: echocardiogram)
History & Physical	EKG
Consults	Emergency Dept. Physician Record
Operative Reports	
Pathology Reports	
Laboratory Reports	
Radiology Reports	

Authorized Representative: is a guardian, parent, or healthcare agent. Example: Legal Documents that support the release of medical information to an authorized representative are:

- Healthcare Power of Attorney
- Power of Attorney
- Marriage License
- Death Certificate
- Executor of estate documents

Financials may include but are not limited to:

- Billing Claims Information
- Itemized Statement