AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT'S NAME: _____ **DATE OF BIRTH:**_____/_____/_____

ADDRESS_____ **PHONE #**_____

I, _____, hereby authorize
FULL NAME OF PATIENT

_____ to release information
NAME OF HOSPITAL/PHYSICIAN/FACILITY

specified below from my medical records covering the dates of service_____ to_____.

The information, which is checked (X) below is to be released to:

_____
NAME OF HOSPITAL, PHYSCIAN, SERVICE AGENCY, THIRD PARTY OR OTHER (Provide fax # if hospital or physician)

_____
ADDRESS **CITY** **STATE** **ZIP**

Purpose for Release: ☐ Medical ☐ Insurance ☐ Legal ☐ Other_____
*Purpose of Release is not required for patient/representative requests.

Check off the items to be released:

☐ Discharge Summary	☐ Pathology Reports	☐ X-ray Report_____	☐ Discharge Instructions
☐ Laboratory	☐ Radiology films	☐ History & Physical	☐ Cardiology
☐ ER Records	☐ Consultation Reports	☐ Clinic Visit	☐ Entire Record
☐ Progress Notes	☐ Abstract	☐ Operative Report	☐ Other_____

Method of Delivery: ☐ Paper ☐ Fax #_____ ☐ Email_____

The patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, and psychiatric treatment. To authorize release of this information, please read and sign the following:

I, _____, authorize the release of **alcohol and/or drug abuse** treatment and information.
(Patient's Signature)

I, _____, authorize the release of **HIV tests results** and/or HIV treatment information.
(Patient's Signature)

I, _____, authorize the release of **psychiatric** information.
(Patient's Signature)

I hereby authorize Minden Medical Center to use/disclose my individually identifiable health information in the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorized by this document is not a health plan or health-care provider that my information may no longer be protected from further disclosure by state or federal law.

- I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization or that refusal to sign this authorization will not affect my treatment.
- I understand that information used or disclosed to an entity other than a health plan or health care provider maybe subject to re-disclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 CFR 160 and 164.
- I understand that this authorization will expire on ____/____/____. (If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)
- I understand that I may revoke this authorization at any time by notifying [enter facility/practice name] in writing, except to the extent that has already taken place in reliance of the previous authorization period.
- I understand that if my records contain sensitive information that I may need to have my physician authorize the use of disclosure of it.
- I understand that I have the right to see this information described on this form if I ask to see it and I understand that I may request a copy of this form after I sign it.

_____ _____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE **RELATIONSHIP TO PATIENT** **DATE SIGNED**

FOR HIM USE ONLY: Date Rec'd_____ Date Processed_____ Time Frame_____ Processed By_____ #Pages/Amount_____