Authorization for Disclosure of Health Information

❒ Hospital ❒ Physician Office (Specify Doctor) ❒ Both

I hereby authorize _____ to release medical information from the records of:
(Name of Facility)

Patient Name: _____ DOB: ___/____/____ SSN: XXX – XX - _____
Patient Complete Address: _____
Patient Phone Number: _____

Information to be disclosed (check all applicable items to be released):

❒ Discharge Summary ❒ ER Record ❒ HIV Testing
❒ Discharge Instructions ❒ X-Ray Reports/Images ❒ Billing Information
❒ History and Physical ❒ Lab Reports ❒ Portal Proxy Access
❒ Consultations ❒ EKG/ECG Tests ❒ Other (please specify) _____
❒ Operative Report ❒ Therapy (PT,OT,ST)

Date(s) of Treatment Requested: _____

Purpose or Need For The Disclosure is:
❒ Continued Medical Care ❒ Insurance ❒ Legal ❒ Patient's Own Use ❒ Other _____

The Information May Be Disclosed to:
Recipient's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Fax #: _____
Email Address: _____
Delivery Method: ❒ Paper ❒ CD/DVD ❒ Email ❒ Fax (Patient Care Only)

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan, or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.
I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.
I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
This authorization expires on: _____ or upon the following event: _____
(Date)
If no date or event is specified, this authorization will expire one year from the date of signature)

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

_____ _____ _____
(Signature of Patient or Personal Representative*) (Date of Signature) (Witness)

Driver's License # _____

***If signed by a personal representative, a description of the representative's authority to act is as follows: (attach proof)**

❒ Parent ❒ Legal Guardian ❒ Health Care Power of Attorney ❒ Administrator
❒ Executor of Estate ❒ Next of Kin ❒ Beneficiary

NO STRAY MARKS BELOW THIS LINE

NORTON KING'S DAUGHTERS' HEALTH

Patient Authorization for Disclosure of Patient Health Information

Patient Name: _____

DOB: _____
(or sticker)

Form # Mo/Yr