PATIENT AUTHORIZATION

I herebr authorize employees, Medical Staff members or other agents of

____

Name of Organization

To use or disclose the following protected health information:

____Copy of the Complete Record (s)
____History/Physical Examination
____Discharge Summary
____Operative Report
____Emergency Department Record(s)
____Lab Report(s)
____Progress Notes
____Radiology Reports/Film(s)
____Pathology Reports
____Other as specified below:

____
____

(If this form authorizes the use or disclosure of psychotherapy notes, it may not be used to authorize the use or disclosure of any other Protected Health Information. A separate authorization is needed for any other use or disclosure,)

To be released about me from the health record of:

Patient Name:________________________________ Date of Birth _________________________

Social Security Number:______________________Date(s) of Treatment___________________
for the following purposes:

____At the request or direction of the undersigned individual

____For marketing -- This organization will/will not (cross out one) receive compensation, whether monetary or otherwise, as a result of the use or disclosure of your health information for marketing.

____For research (Describe) ____
____

____Other (Describe)____

This authorization also includes any information in my medical records regarding diagnosis/treatment of alcohol/drug abuse, psychiatric or mental illness, immunodeficiency syndrome (AIDS) or tests for human immunodeficiency virus (HIV). This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

The health information described above may be used by or released to:

____
____

This Authorization expires:

____On the following date: ---/---/---

____When the following event occurs: ____

____No expiration (permitted only for authorizations used to create or maintain research databases or repositories.

Unless otherwise specified, this authorization will expire six (6) months from the date signed by patient or legal authorized agent, and covers only treatment prior to that date.

You may revoke this authorization at any time, in writing, except to the extent that we have already relied upon it in making a use or disclosure. If you are providing this authorization to obtain insurance coverage, you may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy

If the only reason you have asked us to provide a health care service is so we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this authorization. Example – if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this authorization permitting us to disclose the results to your employer.

I understand this authorization is voluntary and that I may refuse to sign this authorization, and that my refusal will not affect my ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit except as stated above.

I understand that signing this authorization may cause the health information used or disclosed pursuant to this authorization to no longer receive the protection of federal privacy laws.

___________________________________ ___________________________________

Patient's Signature* Date

____

Witness

*The above individual is unable to consent because (check one):

____Minor

____Incompetent

____Other (explain)____

I hereby consent on behalf of the patient name on this authorization.

_________________________________ _________________________________

Signature Relationship

_________________________________ ______________________

Witness Date