AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize: _____

Name and address of facility/health care provider you wish to release information

To release information requested for (either DOB or SID is REQUIRED to identify record):

D.O.B: _____ dd / mm / yyyy **S.I.D:** _____

Name of person making request: _____

To:

For the purpose of: _____

By INITIALING the spaces below, I specifically authorize the release of the following records, if such records exist:

Record Types

Record Types

- ☐ All hospital records (including nursing records and progress notes)
- ☐ Medical records needed for continuity of care
- ☐ Laboratory reports
- ☐ Please send the entire medical records (All information) to the above named recipient
- ☐ Diagnostic imaging reports
- ☐ Laboratory reports
- ☐ Transcribed hospital reports
- ☐ Most recent five year history
- ☐ Emergency and Urgency care records
- ☐ Pathology reports
- ☐ Clinician Office Chart notes

Other: _____

I authorize the information listed below to be used, disclosed, or received by placing my INITIALS next to the information:

Special Records Authorization

Special Records Authorization

- ☐ HIV/AIDS - related records (Copies will not be released to inmates while incarcerated)
- ☐ Genetic testing information
- ☐ Alcohol and Drug information

Mental Health-list specific info requested:

PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

This authorization is limited to the following time period:

This authorization is limited to a worker's compensation claim injuries of:

My signature indicates that I authorize the disclosure of the above information and understand the following: I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits. I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request. I understand this change will not affect information that has already been shared. I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

Signature of Patient
Date: _____ dd / mm / yyyy

Signature of legal/personal representative authorized by law
Date: _____ dd / mm / yyyy