SHARED ELECTRONIC HEALTH RECORD

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION (PHI)

Patient Name: _____
MRN: _____ DOB: _____
Treatment Location: _____

Please Print
Patient Information *must be fully completed*

Name:_____ Date of Birth: _____ Email: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____

***Who** has the information you want released.*

Please list the specific hospital, physician office and/or home health agency

Name: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____

The information to be released may be from my electronic health record (EHR) and/or paper medical records. I understand that the data from the EHR are current as of the date printed. I further understand that in reducing the data to paper, information from the electronic database is being reformatted onto paper and that the page numbers reflect the printed document, not actual pages in the EHR.

Who do you want to receive your information

I hereby authorize the above named hospital/physician office to: ❑ Release medical records to ❑ Speak to/discuss with ❑ Both release medical records to and discuss medical information with:

Name: _____ Attention to: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____ Fax: _____

Information to be released:

What do you want shared? Check appropriate boxes

Routine Record sets - indicate date(s) of service From:_____To:_____

Type of information
- ❑ All Records
- ❑ Behavioral Health Records ❑ Labs
- ❑ Clinic (office visits, immunizations, meds)
- ❑ Radiology Images
- ❑ Radiology Reports
- ❑ Emergency Department
- ❑ Genetic Information and/or Test Results/Pedigree: _____
  (Please specify type of information and/or test to be released)

Type of information
- ❑ Hospital (discharge summary, history & physical, operative report, consults, labs, radiology, emergency)
- ❑ Billing Records
- ❑ Employee Health Record
- ❑ Home Health (Plan of care, orders, visit notes)
- ❑ Other: _____

Authorization to Release Protected Information

I **DO** authorize disclosure of any information relating to Alcohol and/or Drug Abuse ____ **I Do Not**
I **DO** authorize the disclosure of any information relating to diagnosis and or treatment of **Mental Health** ____ **I Do Not**
I **DO NOT** want to review Mental Health information prior to being sent _____**Yes I want to review**
I **DO** authorize disclosure of information which refers to **HIV TEST RESULTS, INFECTION STATUS AND/OR TREATMENT** ____ **I Do Not**

How do you want your information delivered?

Disclosure format(check one)**:**
- ❑ CD
- ❑ Flash-drive
- ❑ Paper

If none selected paper will automatically be sent

Verification of Identification (office use only)

ID verified by:
_____
Staff Initials

Purpose of release (Why is it needed)

❑ Continuing Care ❑ Transfer of Care ❑ Personal Use/Review ❑ Other (specify):_____

Fees may be charged in accordance with State and Federal Statutes

I understand that:

- I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences
- I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, **except** where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits of other insurance coverage or benefits
- I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information
- I understand I am entitled to a copy of this authorization, upon request

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

Signature of Patient or Authorized Representative	Date| Time AM|PM	Printed Name	Witness

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney): _____