Community Memorial Healthcenter

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize Community Memorial Healthcenter to disclose the following information from the medical records of:

Patient Name: ______________________________________ Date of Birth: _________________

Address: ____

Telephone: _____________________ Medical Record Number: ______________

Social Security Number: _____________________

Covering the period(s) of health care:
From _______ to ___________
From _______ to __________

Information to be disclosed:

☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images
OR
Select from the following (check as many as apply):

- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ History and Physical Examination
- ☐ Laboratory Tests
- ☐ Consultation Reports
- ☐ X-ray reports
- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
- ☐ Mental health care or services
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Photographs, videotapes, digital or other images
- ☐ Itemized Bill
- ☐ Other (please specify) ____

This information is to be disclosed to the following individual or entity:

Name: ______________________________________ Relationship: ______________________

Address: ____

Telephone: ____________________________

This information is to be disclosed for the purpose of: ____

____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or on the happening of ____.
Initials: _______________

b. I understand that I may revoke this authorization at any time by notifying the Hospital in writing, but if I do it won't have any effect on any actions the Hospital took before it received the revocation. Initials: _______________

c. I understand that the Hospital cannot make me sign this authorization as a condition to receive treatment from the Hospital except:

(i) When the Hospital provides me with research-related treatment; or

(ii) When the Hospital provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
Initials: __________________

Community Memorial Healthcenter, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(*Form MUST be completed before signing*)

____ ___________________________
Signature of Patient or Representative Date

____
Print Name

____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

____

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***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

____ ___________________________
Verified by Date