Community HOSPITAL

Authorization To Disclose Protected Health Information

Log # _____ Health Record # _____

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Telephone #: _____

Release to: ☐	Or	Release From: ☐
Name of Person, Company, or Organization		Name of Person, Company, or Organization
Address		Address
City, State, Zip		City, State, Zip
Telephone Number Fax		Telephone Number Fax

Method of Release: ☐ In Person ☐ Fax ☐ By Mail

I authorize the use or disclosure of the above-named individual's health information, as described below:

The Following Information is to be Disclosed (please check):

☐ Radiology (X-Ray, CT scan, MRI scan, US) ☐ Reports ☐ Images ☐ Laboratory Tests ☐ Physician Consultation
☐ History and Physical Examinations ☐ Discharge Summary ☐ ER Report
☐ Other Medical Records or Health Information: _____

Sensitive Information:

I understand that the above-mentioned records may include information relating to (check to authorize release):
☐ Acquired Immune Deficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
☐ Med/Psych Rehabilitation ☐ Sexually Transmitted Disease(s)
☐ Diagnosis/Treatment for Alcohol and/or Drug Use ☐ Information for Research Purposes

Community Hospital services provided on (dates): _____

Purpose of This Request:

☐ Continued Care ☐ Personal Use ☐ Other (specify): _____

Disclosure:

I understand that any disclosure of medical information carries with it the potential for re-disclosure, and that the recipient may not be governed by the federal privacy and confidentiality legislation.

Right to Revoke:

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization I must do so in writing and present my written revocation to the Director of Health Record Information Services or the Compliance Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Expiration:

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I do not specify an expiration date, event or condition, this authorization will expire upon release of the information requested, or 120 days from the date of signing.

- **If I have questions about disclosure of my health information, I can contact the Privacy Officer or the Compliance Officer at (970) 644-3015.**
- **I understand that I may request a copy of this authorization form, after signing. I understand that I need not sign this form in order to receive healthcare treatment.**

Signature of Patient or Legal Representative: _____ Date: _____

If Signed by Legal Representative, Relationship to Patient: _____ Date: _____

Signature of Witness (not required): _____ Date: _____

☐ Checked I.D.