

**AUTHORIZATION FOR DISCLOSURE OF
HEALTH INFORMATION**

Patient Name: _____ Maiden/Other Name: _____

Chart Number: _____ Birthdate: _____

I hereby authorize: _____
NAME OF HEALTHCARE PROVIDER

to release my records to: _____
NAME

ADDRESS

The disclosure is being made for the following purpose(s):

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Diagnosis & Treatment | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Insurance/Billing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Personal | |

I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

<u>Information to Be Released:</u>	<u>Date of Service:</u>	<u>Information to Be Released:</u>	<u>Date of Service:</u>
<input type="checkbox"/> Pertinent Records for Continuing Care	_____	<input type="checkbox"/> Radiology Films	_____
<input type="checkbox"/> Discharge Summaries	_____	<input type="checkbox"/> OB/GYN	_____
<input type="checkbox"/> History & Physical	_____	<input type="checkbox"/> Pediatric	_____
<input type="checkbox"/> Report of Operations	_____	<input type="checkbox"/> Immunizations	_____
<input type="checkbox"/> Consultations	_____	<input type="checkbox"/> Oncology	_____
<input type="checkbox"/> Pathology Reports	_____	<input type="checkbox"/> Physical Medicine	_____
<input type="checkbox"/> Laboratory Reports	_____	<input type="checkbox"/> Cardiology	_____
<input type="checkbox"/> Radiology Reports	_____	<input type="checkbox"/> Other: _____	_____

Authorization of Release of the Indicated Sensitive Records (requires patient's initials):

<input type="checkbox"/> HIV or AIDS	_____	<input type="checkbox"/> Psychotherapy/Mental Health	_____
<input type="checkbox"/> Chemical Dependency	_____	<input type="checkbox"/> Other: _____	_____

I release the above-named healthcare provider from all legal responsibility and/or liability that may arise from the release of the records I have specified.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits except as permitted by law.

I understand that I may revoke this authorization in writing at any time to the hospital Privacy Officer except to the extent that action has been taken in reliance on this authorization or if the authorization was obtained as a condition of obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy or the policy itself.

This authorization will remain in effect until: _____ (date). If no date is indicated, authorization will remain in effect for one year from the signature date, and will automatically expire without my revocation.

Signature of Patient or Representative

Date

Name of Personal Representative (if applicable)

Relationship to the patient and representative's authority to act for the patient

Printed Name of Innovis Representative Taking Request