Medical Record, Home Visit, and Media Release

Please prepare your own release form with the help of your hospital's legal department.
This form may serve as a useful example. However, specific requirements for consent vary by location.

Medical Record Release

I authorize the following organizations/individuals:

__ Hospital: _____
__ Insurance Plan: _____
__ Other Providers: _____
_____

to use and disclose a copy of the specific health information described below regarding:

_____
(*Name of patient*) (*Date of Birth*)
_____
(*Street Address*)
_____
(*City, State, Zip Code*)

consisting of:

_____History and physical examinations
_____Laboratory reports
_____Discharge summary
_____Bioelectric output (i.e., EKG, EEG)
_____Other, specify_____
_____Consultation reports
_____Operative reports
_____X-ray/Diagnostic images
_____Tissue and/or blood specimens

to:

_____
(*Name of hot spotter*)
_____
(*Street Address*)
_____
(*City, State, Zip Code*)

for the purpose of: ***Care management and care coordination***

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **INITIALS** in the applicable space next to the type of information.
_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information

This authorization is voluntary, and you may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services from your usual providers; however, your refusal to sign this authorization will affect your ability to participate in this care coordination project.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I understand that my health information may be shared with health care providers, social workers, nurse case managers, health lawyers, community agencies, and other professionals who have been, are currently, or will be involved in my care in order to better coordinate my care.

I have read this authorization and I understand it.
Unless revoked, this authorization does not expire.

By: _____ Date: _____
(*Signature of individual or Legally Authorized Representative*)

Printed Name: _____

Description of relationship to individual: _____

Home Visit/Doctor Appointments Release

I authorize _____ to visit me in my home and to accompany me to doctor
(*Name of hot spotter*)
appointments.

By: _____ Date: _____
(*Signature of individual or Legally Authorized Representative*)

Printed Name: _____

Description of relationship to individual: _____

Media Release

I authorize _____ to:
(*Name of hot spotter*)

- Take my photograph;
- Include me in an audio recording; and/or
- Include me in a video recording.

I further authorize this person to:

- Include my photograph in printed materials;
- Include my photograph and/or audio/video recording in presentations and meetings;
- Include my photograph and/or audio/video recording on any Web sites;
- Include my photograph and/or audio/video recording in other electronic formats (such as CD-ROMs or audio/video downloads); and/or
- Include my full name with any use of my photo or audio/video recording.

I release and discharge this individual and _____ from any and all claims and demands arising
(*Name of hospital*)

out of, or in connection with, the use of my photograph or audio/video recording.

By: _____ Date: _____
(*Signature of individual or Legally Authorized Representative*)

Printed Name: _____

Description of relationship to individual: _____