BSRMR50

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Patient's Full Legal Name) _____ (DOB) _____ (Day Phone #) _____

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

I, AUTHORIZE:_____
(Name of Organization to Disclose Information)

TO DISCLOSE THE FOLLOWING INFORMATION: **Date(s) of Service:**_____

- ☐ Abstract of Record ☐ Anesthesia Record ☐ Operative Report ☐ Other:_____
- ☐ Entire Record ☐ X-rays or Imaging Report ☐ Discharge Summary ☐ Other:_____
- ☐ ED Record ☐ Laboratory Results ☐ Immunization Record ☐ Other:_____

Person/Facility to Receive Information:_____

Disclosure Format (Paper is default if not marked):

☐ **US Mail** ☐ **Electronic format: CD/DVD** ☐ **Radiology Film/CD** ☐ **MyChart**

☐ **eDelivery by Healthport (for patient's only) - email address:**_____

Purpose of Disclosure:

- ☐ Physician ☐ Insurance ☐ Legal ☐ Other (Please specify):_____
- ☐ Disability Determination ☐ Personal ☐ Worker's Compensation _____

Authorization to Release Information:

1. **I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.**

   Special Instructions: _____

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the organization above disclosing the information.
3. 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 facility. 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. Unless otherwise revoked, this authorization will expire 6 months from the date of signature.
4. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied, according to the hospital policy.

Signature of Patient or Legal Representative_____
DATE

If signed by legal representative, relationship to patient:_____

DEPARTMENT USE ONLY

PROCESSED BY:_____ ☐ IDENTITY VERIFIED ☐ SIGNATURE VERIFIED