



ROICOR

**UNIVERSITY HOSPITAL
HEALTH INFORMATION
MANAGEMENT DEPARTMENT**

Authorization for Disclosure of Health Information

I hereby authorize _____ to release medical information from the records of:
(Name of Facility)

Patient Name: _____ D.O.B.: ____/____/____ SS#: ____-____-____

Patient Street Address: _____

City: _____ State: _____ Zip Code: _____

Date(s) of Treatment Requested: _____

Information to be disclosed (check all applicable items to be released):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ER Record | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> X-Rays Reports | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Doctor's Orders | <input type="checkbox"/> Therapy Notes |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> EKG/ECG Tests | <input type="checkbox"/> Pathology Reports | |
| <input type="checkbox"/> Other (please specify): _____ | | | |

Purpose Or Need For The Disclosure Is:

- Continued Medical Care Insurance Legal Patient's Own Use Other _____

The Information May Be Disclosed To:

Recipient's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ or upon the following event: _____

(Date)

(If no date or event is specified, this authorization will expire in 60 days from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, psychiatric/psychological conditions, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

* Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

(Signature of Patient or Personal Representative)*

(Date of Signature)

*If signed by a personal representative, a description of the representative's authority to act is as follows:

- Parent Legal Guardian Health Care Power of Attorney
 Administrator Executor of Estate Next of Kin Beneficiary