Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Printed Name:______________________________ Date of Birth:______________________

Address:____

Telephone: (______)______________________________ Medical Record Number: ____________________

Information to be Released – Covering the Periods of Health Care

Name of Facility: ______________________________

From (date)_______________________ To (date)_______________________

Please check type of information to be released:

☐ Complete health record (DRS)	☐ Diagnosis & treatment codes	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ Radiology reports/images	☐ Cardiac imaging
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill
☐ Discharge Instructions	☐ Pulmonary function results	☐ Immunization Record
☐ Release of Information (ROI) Abstract – History &Physical (H&P), Discharge Summary, Labor & Delivery Note, Operative Report, Procedure Note, Consultation, Laboratory, Pathology, X-ray reports.		

☐ Other (specify)____

Purpose of Request

☐ Treatment/Continuing Medical Care	☐ Personal Use	☐ Billing or claims payment
☐ Legal Purposes	☐ Disability Determination	☐ School/Employment

☐ Other (specify)____

Send / Release Information

☐ **Paper** ☐ **CD** (if available) ☐ **Electronic Portal** (E-mail notification when access is available) ☐ **E-mail**

☐ **Other request as permitted:** ______________

Unencrypted electronic transmissions are not secure. Although it is unlikely, there is a possibility that information in an unencrypted electronic transmission can be intercepted and read by other parties besides the person to whom it is addressed. ***Please initial if you have requested your information to be sent to you in an unencrypted electronic format.*** ***Initial:***______________________

Release to Name:____

Mail to Name:____

Mail to Address:____

E-mail Address:____

Substance Use Disorder, Mental Health, HIV/AIDS, and/or Genetic Information Records Release Notice

Your initials are required to release the following information:

_______Genetic Information (including Genetic Test Results)	_______Mental Health (excluding psychotherapy notes)	_______HIV/AIDS	_______ Drug, Alcohol, or Substance Use

For Drug, Alcohol, or Substance Use Disorder 42 CFR Part 2 records, a separate consent is required prior to release.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Privacy Office at privacy@christushealth.org. Unless revoked, this authorization will expire on the following date or event ______________________________or 180 days from the date of signature. I understand that refusing to sign this form does not affect disclosures of health information that has occurred prior to revocation or other disclosures permitted by law.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996, and other state privacy regulations. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative or Legally Authorized Representative Who May Request Disclosure

I understand that I do not have to sign this authorization and my treatment or payment for services will not be denied if I do not sign this form.

Signature:______________________________ Date:______________________

Authority to Sign if not Patient:____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** ______________________

Verified by:______________________________