AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:		Date of Birth:
Patient Address:		
City:	State:	Zip Code:
Home Phone: (Provide direct number where you can be reached regarding this form or where a voicemail message may be left for you)		Cell / Other Phone:

Disclosure of protected health information is made at my request for:

☐ Change of Insurance ☐ Referral ☐ Other: ____________________

☐ Change of Physician ☐ Personal Records ☐ Legal or Attorney Use

Describe what specific records may be disclosed / check all that apply:

☐ All Records of treatment
☐ Billing Records, statements for services
☐ Nursing Notes, documentation
☐ Operative or Procedure Notes
☐ Physician notes, orders, history & physical
☐ Records from (date) ______________ to (date) ______________
☐ Lab / diagnostic / test results only
☐ Imaging / Radiology Reports
☐ Discharge Summary
☐ Other records / please specify: ____________________

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ Information pertaining to drug and alcohol abuse, diagnosis, or treatment (42 CFR 2.34 and 2.35)
☐ Information pertaining to mental health diagnosis or treatment (Welfare and Institutions Code 5328, *et seq.*)
☐ Release of HIV/AIDS test results (Health and Safety Code 120980 (g))
☐ Release of genetic testing information (Health and Safety Code 124980 (j))

The Facility or Hospital named above is authorized **to disclose (provide)** the records/information. Persons, facilities, providers or others who are authorized **to receive** the records / information:

Physician / healthcare facility or provider name: ____________________

Address: ____________________ Phone: __________ Fax: __________

City: ____________________ State: ______ Zip: __________

Attorney / law firm / other: ____________________ ☐ N/A

Address: ____________________ Phone: __________ Fax: __________

City: ____________________ State: ______ Zip: __________

Please complete more than one form if multiple disclosures to multiple providers is requested.

Unless otherwise revoked, the Authorization expires ____________________ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form. Any services provided after the date of signing will require a new authorization to be completed.

NOTICE: Summit Medical Center and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS: This Authorization to release health information to voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: 1) to conduct research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing signed by you or your representative, and submit it to the Health Information Management Manager, Summit Medical Center, 6350 E 2nd St, Casper, WY 82609. The revocation will take effect when Summit Medical Center receives the request. You are entitled to receive a copy of this Authorization.

I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

____________________ Signature of Patient or Patient's Personal Representative, if applicable

____________________ Date

____________________ Time

____________________ Personal Representative's relationship or legal ability to represent the patient

____________________ Printed Name of Patient or Personal Representative

Printed Address and Telephone Number of Personal Representative: ____________________

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Records Released Via: ☐ Mail ☐ Fax ☐ Patient Pick Up

HSV:
DOB: AGE: SEX:
ADMIT: RM/BED: /
ADM: PT:
MR#: PAT#: