Name:_____Med Rec#_____

AUTHORIZATION FORM FOR USES AND DISCLOSURES OF PATIENT INFORMATION

I hereby authorize:_____ to disclose my protected health information

TO:_____

Phone#_____ Fax #_____

Address_____City_____State_____ZipCode_____

Describe fully the information that is the subject of this authorization and which will be used or disclosed as set forth below:

☐ Discharge summary ☐ Operative report, pathology report, H&P, consultation ☐ Behavioral Health reports and discharge summary

☐ Entire medical record ☐ Other (specify) _____ ☐ Chemical Dependency

☐ ER Report ☐ HIV results

From: (date)_____ to (date)_____

1. I understand that if the person or entity that receives the above information is a not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of Firelands Regional Medical Center, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken.
2. This authorization will expire: _____

_____
Patient Name DOB SS#

_____
Name of personal representative, if applicable

_____
Relationship of personal representative to patient or statement of authority

If the patient is a minor child, I have verifiable authority to sign for the release of his/her medical records. _____

I understand that the information in my health record may include information relating to 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.

_____
Signature of patient (or patient's representative) date

_____
Witness

Records will be released within 30 days per policy. Clerical fee may be assessed. Patient's signature must be witnessed by non-family member. Requester must acknowledge the above by initialing here. _____