Authorization for Disclosure of Protected Health Information

I acknowledge that the Facility will use my information for the purposes of treatment, payment, and health care operations.

I acknowledge my healthcare information will be disclosed for purposes of communicating results, findings and care decisions to my family members and others responsible for my care or designated by me.

I authorize the Facility and my physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records, including without limitation, history & physical, emergency records, laboratory reports, diagnostic reports, physician notes, progress notes, consultations, and discharge summary, during this outpatient visit to the organization which is or may be liable for payment of charges associated with my care and for all other purposes of benefit payment. If for any reason the Facility will need to release information to my employer I will authorize to do so.

I acknowledge and authorize that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, clinical staff, and administrative staff at the Facility, referring physicians, home health agencies, ambulance companies, and such other health care agencies involved in my care during and after treatment from the Facility.

I acknowledge that my medical records will be utilized in the Facility's (and the Facility's affiliates') utilization review, performance improvement, peer review, and other similar processes or studies. I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law. Information contained in my medical records may be extracted and compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Facility may be stored electronically and made available through computer networks to Facility personnel, physicians involved in my care and their offices. I also acknowledge that should I be treated at another facility in the area affiliated with the facility, my medical records may be made electronically available to the other facility, physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities which are not affiliated with our Facility, and affiliated facilities which do not have computerized medical records, will not be able to provide this service.

I acknowledge that I have been given the Facility's Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the Facility's Office Administrator.

Please Initial: _____

Patients Name: _____ D.O. B. _____ SS# _____

I hereby authorize _____to release information to_____.
Facility Name/Provider Name Name/Address of person/organization to which disclosure is to be made

Fax: _____ Address & Phone: _____

Please select the following:

- ❑ History & Physical
- ❑ Demographics
- ❑ CDT Forms
- ❑ MD Progress Notes
- ❑ Diagnostic Reports
- ❑ Measurements/ Volumetric
- ❑ Operation/Surgery Reports
- ❑ List of Medications
- ❑ Other: _____

Date:	I hereby certify and state that I have read, and that I fully and completely understand this Authorization for Disclosure of Protected Health Information, and that I have signed this Authorization for Disclosure of Protected Health Information, knowingly, freely, and voluntarily.
Time:	❑ Patient is medically unable to sign the Authorization for Release of Information/Healthcare Information.
	This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

Patient/Parent/Guardian/Conservator **X**	If other than patient, include relationship **X**
Spouse (if married/available) **X**	Witness (to signature only) **X**

- **Fees/Charges will comply with all laws and regulations applicable to the release of Protected Health Information. (Payment is due at time of release)**