



HIM2

Authorization to Disclose Health Information

1. I hereby authorize (releasing facility) _____
to disclose the following information from the health records of:

Patient Name: _____ Date of Birth _____

Soc.Sec. #: _____ Telephone _____

Address _____ City _____ State _____ Zip _____

2. Dates of treatment/visit: From (date) _____ to (date) _____

3. Information to be disclosed:	Information is to be released to:
<input type="checkbox"/> Complete health records	_____
<input type="checkbox"/> Discharge summary	_____
<input type="checkbox"/> History & Physical	_____
<input type="checkbox"/> Consultation report(s)	_____
<input type="checkbox"/> Lab report(s)	_____
<input type="checkbox"/> Other (Please specify) _____	_____
<input type="checkbox"/> ER	_____
<input type="checkbox"/> Operative report(s)	_____
<input type="checkbox"/> Pathology report(s)	_____
<input type="checkbox"/> X-ray report(s)	_____

4. 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.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company where law provides my insurer with the right to contest a claim under my policy.

6. This authorization will expire in 120 days from date of signature.

7. I understand that once the above information is disclosed the recipient may redisclose it and the information may not be protected by federal privacy laws or regulations.

8. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of Patient or Legal Representation

Date

If Signed by Legal Representation, Relationship to Patient

Signature of Witness

Date