NobleHospital

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: ____________________________________**DATE OF BIRTH:** _________________ **PHONE #:**__________________

I authorize Noble Hospital to use or disclose my protected health information as described below. Only this information may be used and/or disclosed pursuant to this authorization. I authorize the following individual(s) or organization(s) to receive my protected health information:

____

(Person/Organization to Whom Information will be Disclosed)

____

(Street) (City/Town) (State) (Zip Code)

***What to Release:* Date(s) of Service:**____

The type and amount of information to be used or disclosed is as follows *(check off the appropriate item(s) and include other information, where indicated):*

- ❑ Discharge Summary
- ❑ History & Physical Report
- ❑ Operative Report(s): (Specify) ______________________________
- ❑ Emergency Department Report
- ❑ Consultation Reports from: (Please supply doctors' names/dates): ______________________________
- ❑ Lab results (Please describe dates/types of lab tests requested): ______________________________
- ❑ Cardiology/Neurology Reports: (Specify type) __________________
- ❑ Physical Therapy/Occupational Therapy: (Specify type) ___________
- ❑ Outpatient Clinic: (Specify type):_____________________________
- ❑ Photograph Copies
- ❑ Work Connection (OHC): (Specify Dates) ______________________
- ❑ X-ray/Imaging Reports (Please describe dates/types of reports requested): ____
- ❑ Other (Please specify):____

If not patient: Name of person, authorized by patient, to obtain record, if applicable (NOTE: Photo ID will be required):

____/_______________________________________

Name of Person/Relationship

Purpose of Request:

- ❑ At the Request of the Individual
- ❑ Legal
- ❑ Sharing with other Health Care Providers As Needed
- ❑ Other (please describe): _____________________________________

Release of Special Information: (*Check appropriate response and initial, if applicable*)

- ❑ I **DO** authorize to release information pertaining to psychiatric, drug and/or alcohol abuse, sexually transmitted diseases or genetic testing, diagnosis and/or treatment. Initials: _______
- ❑ I **DO NOT** authorize to release information pertaining to psychiatric, drug and/or alcohol abuse, sexually transmitted diseases or genetic testing, diagnosis and/or treatment. Initials: _______
- ❑ I **DO** authorize to release information pertaining to HIV/AIDS related testing, diagnosis and/or treatment. Initials: _______
- ❑ I **DO NOT** authorize to release information pertaining to HIV/AIDS related testing, diagnosis and/or treatment. Initials: _______

Individual Rights: I understand the following:

- ➢ I need not sign this form to ensure healthcare treatment or payment.
- ➢ I have the right to revoke this authorization at any time.
- ➢ If I revoke this authorization I must do so in writing to the attention of the Health Information Management Department at Noble Hospital.
- ➢ My right to revoke does not apply to information that has already been released on the basis of this authorization nor will it apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- ➢ If I authorize Noble Hospital to disclose information, the recipient of the information might disclose it to others, and any information disclosed by Noble Hospital may no longer be protected by the federal rule on the privacy of medical records.
- ➢ There may be a charge for providing copies of medical records.
- ➢ I understand that I will be given a copy of this authorization form, after signing.

Expiration Date: This authorization will expire in **180** days unless revoked or otherwise specified to be the following date, event or condition ____.

❑ **Photo Identification Obtained/Copied**

Signature of Patient or Personal Representative:____ ***Date***: __________________

If signed by Personal Representative, relationship to patient: ____

Signature of Witness: ____ ***Date:*** __________________

#19-7 (Rev.8/09)

Original – Medical Record Copy – Patient/Personal Representative