

Authorization for Disclosure of Protected Health Information

PLEASE PRINT

Patient Name: _____ Phone: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

1. I authorize the following **TO DISCLOSE** my health information:

Name: _____

Address: _____

Phone: _____

Fax: _____

2. Individual or entity authorized **TO RECEIVE** my health information:

Name: _____

Address: _____

Phone: _____

Fax: _____

3. Purpose for which disclosure is to be made:

- Personal use
 Continuing Care
 Legal
 Insurance Application
 Other:

4. Information to be disclosed:

- Entire Record
 Recent Lab results
 Operative Report
 Radiology Images
 Recent Chart Notes
 History and Physical exam
 EKG
 Radiology Report

By initialing the space(s) below, I am specifically authorizing the release of the following:

_____ Medical Records from alcohol and/or drug abuse treatment center(s)

_____ Mental Health/Psychiatric records

_____ HIV(human immunodeficiency virus) test results/AIDS/sexually transmitted diseases

5. I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Brookings Medical Center, it's employees, and my care providers from all liability arising from this disclosure of my health information.

6. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Printed Name

Relationship to Patient

Signature of patient or legal representative Date

Signature of Witness Date