

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

(All fields must be completed)

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

ORGANIZATION AUTHORIZED TO RELEASE HEALTH INFORMATION (Check all that apply):

- Woodlawn Hospital Woodlawn Medical Professionals Rochester Orthopedics Fulton Co. Medical Clinic
 Akron Medical Clinic Argos Medical Clinic Shafer Medical Rochester Pulmonary Services
 Other: _____

INFORMATION TO BE DISCLOSED:

Dates of service to be released: From: _____ To: _____

- Radiology Report Discharge Summary Emergency Room Report Immunization Record
 Radiology Images History & Physical Consultation Report Entire Medical Record
 Laboratory Report Operative Report Pathology Report Itemized Bill
 Office Notes Other (specify): _____

I authorize the release of information from my record that may include the following:

YES NO

- Behavioral or mental health services
 Treatment of alcohol and/or substance (drug) abuse
 Testing for HIV, HIV test results, diagnosis of HIV positive, AIDS, ARC or other AIDS related disease.

PURPOSE OF REQUEST

- Continuation of Care Personal Use Payment of Claim Legal/Pending Legal Action
 Other (specify): _____

RELEASE HEALTH INFORMATION TO:

Name: _____ Phone No: _____

Address: _____

VIA: Paper/photocopy Electronic/Digital Media Other _____

Right to Revoke Authorization & Length of Time Valid: I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management (HIM) Department and/or other hospital owned facility. I understand that the revocation will not apply to information that has already been released in response to this authorization or my insurance company when the law provides my insurer the right to contest a claim under my policy.

___*Unless I specify differently, this authorization will expire on (date or event) _____. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date of signature.

Re-disclosure/Signature of Patient or Personal Representative Who May Request Disclosure: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information. I understand that authorizing the use or disclosure of the health information identified is voluntary and I can refuse to sign. I need not sign this form in order assure treatment.

Patient Signature or Legal Representative_____
Legal Representative Relationship/Authority_____
Date**(FACILITY USE ONLY)****ROUTE OF DISCLOSURE:** Personal pick-up Mail FAX (#) _____ - Phone (#) _____**Disclosure Media:** Printed/photocopy Electronic/Digital Media Other _____Identity of Requester Verified with: Photo ID Matching Signature Other (explain): _____

Identity of Requester Verified by: _____ Date: _____

Date Records Released: _____ Person Releasing Records: _____