AUTHORIZATION FOR USE, REQUEST AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Freestone MEDICAL CENTER

Medical Record Number:	Date of Birth:	Phone Number:
Address:	City:	State:
Patient Number:		

I, _____, authorize Freestone Medical Center or_____, to disclose and provide copies of the health-care information indicated below from my record to the following entity, person, or class of person:

_____ _____
Name of person(s) or company to receive information Phone Number

_____ _____ _____ _____
Street Address City State Zip Code

Information to Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Admission Sheet History and Physical Discharge Summary Other Healthcare Records (created by another provider

Entire Record Operative Report Pathology Report Radiology Report (XR, MRI, Ultrasound, ect)

Entire Record Laboratory Report Emergency Room Complete Billing Record Other

Drug and/or alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records release

I understand and agree that the information requested may contain reference(s) to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and/or other sensitive information.

Format:

Paper Compact Disc (CD)

Purpose of Request/Disclosure

Treatment or Consultation At the request of the Patient Billing or claims payment Requested for Government Benefit

Other, (specify) _____

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and accountability Act of 1996. This facility, its employees, officers and physicians are hereby released from any Legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This authorization will automatically expire in 180 days from the date of signature unless (1) an expiration event or date is provided; or (2) "none" has been entered (only if the purpose of this authorization is research).

_____ Expiration Date or Event (eg, discharge from hospital of requested information)

I understand that this authorization may be revoked by me or my personal representative by written and dated notice to except to Freestone Medical Center except to the extent that disclosure of information has been made prior to receipt of the revocation by Freestone Medical Center.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for service will be denied if I do not sigh this form Unless specified above under Purpose of Request. I can inspect or obtain a copy of the protected health information to be used or disclosed.

_____ _____ _____
Signature of Patient Date Signed Time

Authority to Sign if not Patient _____ Date _____

Identity of Requestor Verified Via Photo ID Matching Signature Other specify _____