Authorization To Disclose Health Information

Patient's Name: ____________________ Phone: ____________________
Address ____________________
Social Security # ____________________
Date of Birth: ____________________ Date(s) of Service: ____________________

I authorize the use or disclosure of the above named patient's health information as described below:

FROM:		TO:	
Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	

FOR THE PURPOSE OF: (Check all that apply.)

❑ Continued Care ❑ Legal ❑ Insurance ❑ At Request of Patient ❑ Other (explain) ____________________

INFORMATION TO BE DISCLOSED:

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

❑ Record Abstract ❑ Discharge Summary ❑ HIV/AIDS
❑ History & Physical ❑ Emergency Department Record ❑ Substance Abuse
❑ List of Allergies ❑ Medication List ❑ Mental Health
❑ Immunization Record
❑ Laboratory Results from (date) ____________________ to (date)
❑ X-ray and Imaging Reports from (date) ____________________ to (date)
❑ Consultation Reports from (doctors' names) ____________________
❑ Entire Record
❑ Other ____________________

This authorization is voluntary. Heartland Neurosurgery will not condition your treatment on this authorization.

I understand that I have a right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the Health Information Department. I understand that my revocation will not apply to information that has already been released in response to this authorization.

I also understand that I have a right to view and/or receive copies of my health information and that there may be a charge for copies. In support of your privacy, Heartland Neurosurgery does not accept your blanket authorization to disclose health information of treatment not yet received. A new authorization will be required for each new episode of care. I understand that if I refuse to authorize the disclosure of information, the information may not be released. Refer to the Notice of Privacy Practices for more information about your rights with your health information.

I understand that the information in my health record may include information relating to mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that if I refuse to authorize the disclosure of information, the information may not be released.

This authorization automatically expires 365 days from the date this authorization is signed by the patient below unless otherwise noted

____

Signature of Patient or Authorized Representative ____________________ Date ____________________

If Signed by Authorized Representative, Relationship to Patient ____________________ Date ____________________

Signature of Witness ____________________ Date ____________________

If unable to sign document, give reason ____________________

NOTE: Re-disclosure of this information may be permitted.

❑ This information has been disclosed to you from records protected by Federal laws and regulations protecting substance abuse treatment program records (42 C.F.R. part 2). The Federal rules prohibit you from making any further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for the purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.