AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Name: _____ Health Record # _____ D.O.B. _____

Label

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure: _____

   _____

3. The type of information to be used or disclosed is as follows (check boxes and include other information where indicated.

☐ Discharge Summary	☐ History & Physical	☐ Operative Report
☐ Lab Work	☐ X-Rays	☐ EKG / Echo
☐ Pathology Reports	☐ E.R. Report	☐ Progress Notes
☐ Physician's Orders	☐ Nurses Notes	☐ Face Sheet

   Other: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and the treatment for alcohol and drug abuse.

5. The information identified above may be used or disclosed to the following individual(s) or organization(s):

   Name: _____

   Address: _____

6. The information for which I'm authorizing disclosure will be used for the following purpose:

   ☐ my personal records ☐ sharing with other health care providers as needed

   ☐ Other: _____

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written revocation to the CRMC Privacy Officer(s). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire _____

9. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

_____ _____ _____

Signature of patient or legal representative (relationship if not patient) Date

_____ _____

Signature of Witness Date

-
//
//

COLQUITT REGIONAL MEDICAL CENTER