AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Patient Date of Birth: _____

Patient Phone #:_____ Social Security #:_____

I hereby authorize Weatherford Regional Hospital to use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and address of Individual/Facility/Company to Receive PHI

Name:_____ Address: _____ Phone: _____

Information authorized for disclosure:

Dates of Treatment: _____ _____
Date from Date to

(Please check all that apply)

____HISTORY AND PHYSICAL ____DISCHARGE SUMMARY ____OPERATIVE REPORTS
____LAB / PATHOLOGY REPORTS ____RADIOLOGY REPORTS ____ORDERS
____EMERGENCY ROOM REPORTS ____PROGRESS NOTES ____ RADIOLOGY CD/FILMS
____OTHER: _____

The information will be obtained, used, or disclosed for the following purpose(s) only:

__ Insurance __ Continued treatment __ Legal __ At the request of the patient or patient's representative
__ Patient Portal: E-mail:_____ __ Other (specify)_____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one week from the date of signature or upon occurrence of the following event: _____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements and this form is not sufficient for that purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse. If psychiatric information is included in the information to be released to the patient, physician consent for such release must be obtained.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Description of Legal Representative's Authority **Expiration Date of Authorization**

_____ _____
Witness **Medical Record Number (office use only)**

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

Date of service copied and released:_____