ROI

Caring People . . .
Caring Tradition
CGH MEDICAL CENTER
www.cghmc.com

Date to be picked up _____
Appointment Date _____
Initials/Date_____

AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTH INFORMATION

Authorization is given for the use or disclosure of the named individual's health information as described below.
CGH Medical Center is authorized to make the disclosure or obtain PHI from another source.
Please refer to the CGH Medical Center Notice of Privacy Practices at cghmc.com

PATIENT NAME:_____MRN#:_____

ADDRESS:_____BIRTH DATE:_____

_____TELEPHONE:_____

SPECIFIC INFORMATION TO BE DISCLOSED OR OBTAINED:

Medical Records:

- ☐ Hospital Abstract/date(s)_____
- ☐ Physician Records/date(s)_____
- ☐ Lab/Tests/date(s)_____
- ☐ Immunization Records/date(s)_____
- ☐ Other/date(s)_____

Images/Video:

- ☐ Test/date(s)_____

To Release to: _____
(Healthcare Facility, Individual, or Agency, etc)
_____**Fax Number**_____

To Receive from: _____
(Name of Healthcare Facility)
_____

For the Purpose of: _____(See back for Clinic)

I understand that these health records may include information relating to **BEHAVIORAL OR MENTAL HEALTH SERVICES, TREATMENT FOR DRUG/ALCOHOL ABUSE, PHYSICAL ASSAULT/ABUSE/NEGLECT, AND/OR SEXUALLY TRANSMITTED DISEASES INCLUDING HIV/AIDS.** Note: Witnessed patient signature required for release of sensitive information as described here.
I understand that:

- I may inspect or copy the information to be disclosed. The individual or company requesting the health information is responsible for appropriate copy charges.
- I have the right to revoke this authorization at any time and must do so in writing and present to the Health Information Dept. (hospital) or PFS Dept. (clinic). Such revocation does not apply to information already released in response to this authorization.
- Unless otherwise revoked, this authorization expires on the following date, event, condition:_____
- If no expiration date, event, or condition is given, this authorization expires in sixty (60) days from date of request.
- Authorizing the disclosure of this health information is voluntary. My refusal to sign this authorization does not condition uses and disclosures of PHI permitted for treatment, payment, and healthcare operations.
- Treatment may not be conditioned on obtaining this authorization unless the treatment is soley for research purposes.
- If this authorization is for marketing purposes, I will be informed if it involves remuneration to CGH.
- Disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality rules.

_____ _____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **WITNESS** **DATE**

_____ _____
If signed by Legal Representative, note relationship to patient and verify proof of authority **Information Released By (Employee Signature)**

Fees in accordance with HIPAA Law CFR 164.524 (c)(4):
$1.02 per page (pages 6-25) _____x $1.02=_____
68 cents per page (pages 26-50) _____x $0.68=_____
34 cents per page (pages 51 +) _____x $0.34=_____
Microfiche ____ x$1.71=_____ Electronic 50% of per page fee=_____

_____Total Pages

☐ **Paid/date_____**