AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

MEMORIAL HOSPITAL of CONVERSE COUNTY
Advanced Medicine. Hometown Care.

THIS FORM MUST BE FILLED OUT COMPLETELY (Black/Blue ink ONLY)

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____ Daytime Telephone: _____

Information To Be Released From: (Please be specific)

Provider Name/Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

Release Information To: (please be specific)

Provider Name/Organization/Other Person: _____

Address: _____

Phone Number: _____ Fax Number: _____

Reason for Release: _____ (must complete)

Dates of Service: _____

Information to be Disclosed:

☐ History and Physical	☐ X-ray Reports	☐ Radiology Films
☐ Discharge Summary	☐ Lab Reports	☐ Billing Information
☐ Operative Report	☐ EKG Reports	☐ Physician Office Notes
☐ Pathology Report	☐ Emergency Department Record	☐ Other (specify) _____

Disclosure Requiring Special Consent:

By initialing, I specifically authorize the release of the following confidential information:

☐ HIV test, test result and related information including high-risk behavior documentation.
☐ Drug/alcohol diagnosis, treatment or referral information.
☐ Mental health treatment information.
☐ Other (specify): _____

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 my written revocation to the Health Information Management department. 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. Unless otherwise revoked, the authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, this authorization will expire in twelve months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of health information, I can contact the Health Information Management department at MHCC.

_____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness Date

For Facility Use:

Date Received:_____ Date Information Released: _____

Person/Department Sending Records: _____

0110 / 12-19 (edl)

Memorial Hospital of Converse County

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (ROI)

Patient Information Label