Southeast HEALTH

SOUTHEAST HEALTH AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient (Printed)

Previous Names (if applicable)

Date of Birth

Telephone Number(s)

Address

Fax Number (if applicable)

City State Zip

Email (if applicable)

Purpose of Disclosure: Check appropriate box or write in other purpose.

[ ] Self (If selected, drop down to Expiration) [ ] Legal [ ] Workers' compensation
[ ] Continuity of Care [ ] Forms completion [ ] Other, specify
[ ] Disability [ ] Insurance _____

Information to be Released From: (please be specific)

Provider Name

Clinic (if applicable)

Address

Phone Number

City, State, Zip

Fax Number

Send Information to: (please be specific)

Provider Name/Organization

Address

Phone Number

City, State, Zip

Fax Number

Expiration:

This authorization will expire in 1 year from date of signature *unless another date is specified:*_____

❑ **By checking this box** I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

❑ **By checking this box** I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

Delivery of Information:

Records will be mailed unless an alternate method is checked:

❑ Pick−up at Southeast Health Medical Records/HIM ❑ Fax (number listed above)

❑ CD/DVD ❑ USB flash/thumb drive

❑ Email address: ❑ use email listed above ❑ other:_____

❑ Unencrypted email: The risks of receiving medical records via unencrypted email have been explained to me, including the risks of being hacked or interception by an unintended recipient. Despite being advised of these risks and encouraged to receive records through an encrypted email, I wish to receive the records requested via unencrypted email.

❑ Other, specify_____

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Southeast HEALTH

SOUTHEAST HEALTH AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (CONT.)

Name of Patient (Printed) _____ Date of Birth _____

Information to be Disclosed:

Dates of Service: _____

[ ] Medical Records from the last two years [ ] Billing Claim Form
[ ] Summary Health Information [ ] Detailed Billing Statement
[ ] Complete Designated Record Set

[ ] Other: _____

Signature and Date: The patient or legal representative must sign and date this authorization.

- This authorization may be revoked at any time by providing a written notice of revocation to the Southeast Health HIM department except to the extent that SEH has already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re−disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I understand that SEH will not condition treatment on whether I sign this authorization.
- I may request a copy of this signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Signature (required) **Date** (required) (*mm−dd−yyyy)*

Printed Name of Person Signing **(if not patient)** *(First, Middle, Last)*

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

❑ Parent ❑ Stepparent ❑ Legal guardian ❑ Foster parent ❑ Health care power of attorney/agent ❑ Other _____

Disclosures Requiring Special Consent:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

[ ] HIV/AIDS virus [ ] Sexually Transmitted Diseases [ ] Mental Health/Psychiatric Disorders [ ] Drug, Alcohol Abuse/Treatment

Signature of Patient or Representative _____ Relationship to Patient _____ Date _____

For Facility Use:
Date Received: _____ Medical Record Number: _____ Date Information Released: _____
Person/Department Sending Records: _____

A verbal consent was obtained for this release of information. The following three questions were asked and answers verified:

❑ Last 4 of SSN or year of birth ❑ Who is/are listed as emergency contact(s) ❑ Who is your insurance carrier
❑ Reason or CC for last visit ❑ Who is PCP

Verbal consent obtained by: _____ _____
Printed name Date

_____ _____
Signature Time of call