AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

I _____ hereby authorize Whitman Hospital & Medical Clinics
(**Requester's Name**)
to release information contained in:
_____ medical record, including alcohol and drug abuse records
(**Patient's Name**)
protected under the regulation in Code 42 of Federal Regulations, Part 2, if any; psychological and psychiatric records, if any; social records, if any; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of Acquired Immunodeficiency Syndrome (Aids) ARC (AIDS related Complex), if any; and records of communicable diseases, if any; to the individuals listed below.

NAME OF INDIVIDUAL/ORGANIZATION: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

PATIENT IDENTIFICATION

Patients Date of Birth: _____ **Date(s) of Treatment:** _____

Name Used at Time of Treatment: _____

RECORDS TO BE RELEASED (Select all that apply)

____ **Whitman Med Clinic**	____ **EKG Report**	____ **Discharge Summary**	____ **Operative Reports**
____ **Gastro Clinic**	____ **ER Records**	____ **Lab Report**	____ **Radiology Images on CD**
____ **General Surgery Clinic**	____ **Progress Notes**	____ **Pathology Reports**	____ **Radiology Reports**
____ **Orthopedic Clinic**	____ **History & Physical**	____ **Therapy Notes**	____ **Covid Results**

____ **Other, specify:** _____

PURPOSE OF DISCLOSURE (Select all that apply)

THE INFORMATION BEING DISCLOSED IS FOR THE PURPOSE OF:

☐ **Personal** ☐ **Insurance** ☐ **Attorney** ☐ **Continuing Health Care** ☐ **Other:** _____

SIGNATURE

Signature: _____ **Date:** _____ **Relationship To Patient:** _____

RIGHTS OF THE PATIENT:

- The information listed here above is to be released for the stated purpose only. Any other use is forbidden.
- This authorization is voluntary and I may refuse to sign this form. I will not be refused treatment if I refuse to sign this form.
- This authorization is valid for a period of 90 days. I understand that I may also revoke authorization at any time by contacting Health Information Management at Whitman Hospital and Medical Clinics. My revocation must be in writing. However, the hospital is not responsible for actions already taken based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law. .

FOR STAFF USE ONLY

Identification check: Yes ☐ No ☐ **Form of ID** _____ **Initials** _____ **MR #** _____

Information given to patient Yes ☐ No ☐ **By Dept:** _____ **Initials** _____ **Date:** _____