

## Authorization for Release of Protected Health Information

I hereby authorize Chilton Memorial Hospital (CMH) or \_\_\_\_\_ to disclose to the person(s) named, information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatment I have indicated below. I understand that this consent shall operate as a complete release of liability to the hospital and to its employees for the release of information as specified below.

PURPOSE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

*\*For continuing care purposes we send directly to the physician/facility at no charge. All others: \$10.00 search fee, plus \$1.00 per page fee. If needed for an upcoming appointment, please include the date of appointment so that we may properly prioritize this request.*

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

DATES OF TREATMENT: \_\_\_\_\_

**SPECIFIED REPORTS: (Check appropriate boxes)**

- Abstract: face sheet, history & physical, discharge summary, all medical tests, operative section
- All Medical Tests: labs, ekg, xray, operative section
- HIV/AIDS Treatment records (*if your information contains HIV/AIDS related information you must check this box*)
- Drug/Alcohol Treatment records
- Psychiatric treatment records
- Genetic
- OTHER: \_\_\_\_\_

*\*\* Processing time will vary due to the status of the record.*

*\*\* Pre-payment notice will be mailed – when payment is received, the records will be released.*

**RELEASED TO:**

NAME: \_\_\_\_\_ Phone #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ Fax #: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

Unless otherwise revoked by me, this authorization is valid for 6 months from the date above. Revocations MUST be made in writing, Revocation may not be made if action has already been taken in reliance on this authorization.

I understand that once CMH discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, CMH cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize CMH to use or disclose my health information in the manner described above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

Patient is unable to sign because: \_\_\_\_\_

\_\_\_\_\_  
Signature of authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

### NOTICE TO RECIPIENT OF INFORMATION

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules 42C.F.R. Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42C.F.R. Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient