MEDICAL RECORD AUTHORIZATION

Patient Name: ______________________________

Date of Birth: ______________________________

Social Security Number: ______________________________

1. I authorize **(name of health care provider)** ______________________ to disclose my health information specific to the following date or time period: ______________**THROUGH CURRENT DATE**

2. Individual or entity(s) authorized to receive my health information:

3. Purpose for which disclosure is to be made: <u>**REVIEW**</u>

4. Information to be disclosed: **(check all that apply)***

■ **Please send the entire medical record (all information) to the above named recipient**.

☒ Discharge Summary
☒ History & Physical Exam
☒ Operative Report
☒ Emergency Room Report
☒ Laboratory Report
☒ Radiology Report
☒ Pathology Report
☒ Consultation(s)
☒ EKG
☒ Transcribed Hospital Reports
☒ Clinician Office Chart Notes
☒ Billing Statements

☒ Other: Any transcribed report, Admission History & Physical, Discharge Summaries, Operative Reports, Consultation Reports, specifically including, but not limited to, Radiology Reports, and Pathology Reports.

* I understand that this will include health information relating to (check <u>only</u> if applicable):

❑ HIV (human Immunodeficiency Virus) Infection
☒ Mental Health
❑ Treatment for alcohol and/or drug abuse
❑ Genetic Testing

5. I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations.

6. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below unless revoked earlier.

7. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, or similar Records Custodian, knowing that previously disclosed information would not be subject to my revoke request.

8. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

____
Signature of Patient or Patient's Legal Representative

____
Date

____
Print Name of Patient or Legal Representative

____
Legal Representative's Relationship to Patient

This authorization complies with 45 CFR 164.506 and 45 CFR 164.508 regarding uses and disclosures of individually identifiable health information as recognized by the Health Insurance Portability and Accountability Act (HIPAA).