PRATT • REGIONAL MEDICAL • CENTER

Authorization For Release Of Protected Health Information

PATIENT NAME:	ACCT. #:	MR #:
ADDRESS:		DOB:

CHECK ONE:

☐ I hereby authorize PRMC to use PHI concerning the above-named person.

☐ I hereby authorize PRMC to disclose PHI concerning the above-named person to _____.

☐ I hereby authorize _____ to disclose PHI concerning the above-named person to PRMC.

COMPLETE THE FOLLOWING:

For treatment date(s): _____

For the following purpose(s): _____

If request is initiated by the individual (or representative), insert "at the request of individual;" otherwise, describe purpose of the use of disclosure.

INFORMATION TO BE DISCLOSED:

☐ History & Physical	☐ Progress Notes	☐ Discharge Summary	☐ Operative Reports
☐ Lab / Path Reports	☐ X-Ray Reports / Films	☐ Face Sheet	☐ Itemized Billing Statement
☐ ER Record	☐ Photographs / Video Tapes	☐ Other (Specify:)_____	

Expiration: This "Authorization" will expire 60 days from date signed.

AUTHORIZING SIGNATURE

- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed and no longer protected by those regulations.
- I may inspect or receive a copy of any records / information used or disclosed under this authorization.
- I also understand that I may revoke this authorization at any time by delivering a written revocation to the Director of Health Information Management.
- If I revoke this authorization it will have no effect on actions already taken on this form.
- I authorize the use or disclosure of the records information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.
- I understand that my health information may contain information relating to HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment or other conditions which may be specifically protected by law, and I authorize disclosure of that information. I understand that once my health information has been disclosed that it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it.
- I understand that I may refuse to sign this Authorization and that my treatment, or payment for my treatment will not be affected unless my treatment includes research, or the reason for my treatment is to disclose the information to another person.

_____ Signature of Patient or Patient's Personal Representative	_____ Date of Signature(s)
_____ Signature of Witness	_____ Personal Representative's Relationship to Patient