

Regions Hospital Use Only
MRN _____
Release ID _____

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Information	Patient Name _____ Patient Former Name _____ Date of Birth _____ Patient Phone (____) _____ - _____ Address _____ City _____ State _____ Zip _____												
Health Information Released FROM	<input type="checkbox"/> Regions Hospital and Regions Clinics <input type="checkbox"/> Other _____ Address _____ City _____ State _____ Zip _____												
Health Information Released TO	Individual Name _____ Phone (____) _____ Organization Name _____ Fax # (____) _____ Address _____ City _____ State _____ Zip _____												
Purpose of Disclosure	<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Personal <input type="checkbox"/> Disability <input type="checkbox"/> Legal/Attorney <input type="checkbox"/> Other (Please Explain) _____												
Health Information to be Released	<input type="checkbox"/> Copies of Records <input type="checkbox"/> Verbal Exchange (no copies) <input type="checkbox"/> Entire Health Record (initial here) _____ <input type="checkbox"/> Hospital admission (date) _____ <input type="checkbox"/> Emergency room visit (date) _____ <input type="checkbox"/> Clinic Visit (date) _____ <input type="checkbox"/> History and physical report <input type="checkbox"/> Laboratory results <input type="checkbox"/> Consultation Report <input type="checkbox"/> Procedure / operative report <input type="checkbox"/> X-ray / imaging results <input type="checkbox"/> Discharge summary <input type="checkbox"/> Medication administration report <input type="checkbox"/> Radiology image film / CD <input type="checkbox"/> Discharge instructions <input type="checkbox"/> Other (described here) _____ <i>Unless specifically excluded, behavioral health/mental health information and/or HIV information appearing in the information selected above will be disclosed. Please exclude: _____</i> If initialed here _____, my chemical health treatment program record may be disclosed.												
Method of Delivery	<input type="checkbox"/> Mail to Recipient <input type="checkbox"/> Pick up on ____/____/____ (photo ID required at pick-up) <input type="checkbox"/> Fax to: _____ <input type="checkbox"/> Other: _____												
Authorization	<p>This authorization expires (ends) on the following date, event or condition: _____</p> <p>This authorization will expire no more than twelve (12) months from the date I sign this form, unless otherwise specifically permitted by law.</p> <p>I understand that:</p> <ul style="list-style-type: none"> • I may revoke this authorization at any time by notifying, in writing, the healthcare facility listed in Section 1 above. • Revoking this authorization does not apply to information that has already been released under this authorization. • I have the right to inspect or obtain a copy of the health information to be disclosed. • If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws. Information that goes to other persons/entities may <u>not</u> be protected by state or federal privacy laws and may be re-disclosed. • I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as a life insurance company. <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;"> _____ <i>Signature of Patient or Patient's Representative</i> </td> <td style="width: 20%; border: none;"> _____ <i>Signature Date</i> </td> <td style="width: 20%; border: none;"> _____ <i>Time</i> </td> </tr> <tr> <td style="border: none;"> If signed by patient's representative: </td> <td colspan="2" style="border: none;"></td> </tr> <tr> <td style="border: none;"> _____ <i>Print name of representative</i> </td> <td colspan="2" style="border: none;"> _____ <i>Relationship to patient</i> </td> </tr> <tr> <td style="border: none;"> _____ <i>Signature of Witness</i> </td> <td colspan="2" style="border: none;"> _____ <i>Print name of witness</i> </td> </tr> </table>	_____ <i>Signature of Patient or Patient's Representative</i>	_____ <i>Signature Date</i>	_____ <i>Time</i>	If signed by patient's representative:			_____ <i>Print name of representative</i>	_____ <i>Relationship to patient</i>		_____ <i>Signature of Witness</i>	_____ <i>Print name of witness</i>	
_____ <i>Signature of Patient or Patient's Representative</i>	_____ <i>Signature Date</i>	_____ <i>Time</i>											
If signed by patient's representative:													
_____ <i>Print name of representative</i>	_____ <i>Relationship to patient</i>												
_____ <i>Signature of Witness</i>	_____ <i>Print name of witness</i>												