PATIENT AUTHORIZATION FOR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION

GENERAL INFORMATION

LAST NAME:		FIRST NAME:
MAIDEN NAME OR OTHER NAME USED:	DATE OF BIRTH:	PHONE:
ADDRESS:		
CITY:	STATE:	ZIP:

I HEREBY AUTHORIZE: (PLEASE PRINT)

FACILITY: ______________________________

ADDRESS: ______________________________

PHONE: ________________ FAX: ____________

TO RELEASE TO: (PLEASE PRINT)

FACILITY: ______________________________

ADDRESS: ______________________________

PHONE: ________________ FAX: ____________

THE FOLLOWING INFORMATION FROM MY RECORDS:

☐ COPY OF COMPLETE HEALTH HISTORY ☐ LABORATORY REPORTS ☐ X-RAY REPORTS ☐ BEHAVIORAL HEALTH

☐ OTHER: (PLEASE SPECIFY) ______________________________

COVERING THE PERIOD FROM: ______________________________

INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF: ______________________________

____

THIS AUTHORIZATION WILL EXPIRE ON: (SPECIFY DATE, EVENT, OR CONDITION) ____________________

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and present my written revocation to Hunter Health. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty (60) days from the date below.

I understand that treatment is not conditioned upon the execution of this authorization. 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 described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, $16.00 for pages 1-10, $28.00 for pages 11-50 ($16.00 for pages 1-10 and $12.00 for pages 11-50), an additional $0.35 per page for anything above 50 pages. A records retrieval fee of $20.00 plus $0.35 per page will be charged for records stored off site.

Hunter Health is not responsible for completeness, legibility or omittance caused by the copying of any medical records from another institution.

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SIGNATURE OF PATIENT OR LEGAL GUARDIAN | RELATIONSHIP TO PATIENT | DATE

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PATIENT'S NAME | PRINT NAME OF PATIENT OR LEGAL GUARDIAN

FOR HUNTER HEALTH STAFF USE ONLY: COMPLETED BY: ______________________ DATE: ____________

☐ REVOKED DATE: ____________ ☐ HANDED TO PATIENT ☐ FAXED ☐ MAILED ☐ OTHER: ____________