



# I-70 Community Hospital

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient Name:		Birth Date:		Social Security No. (optional):	
Recipients Name, Address & Contact Information:					
_____					
_____					
_____					
This authorization will expire on the following: (Fill in the Date or the Event but not both.)					
Date: _____ Event: _____					
Purpose of Disclosure:					
_____					
_____					
_____					
Description of information to be used or disclosed					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheet		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath Lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92 <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that:					
1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. 6. I will receive a copy of this form after I sign it.					
Section B: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Guardian/Patient/Representative: _____			Date: _____		
Print Name of Patient/Patient's Representative: _____			Relationship to Patient: _____		