Union County General Hospital
Fax 575-374-0139
PH# 575-374-2585 ext.7018

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME	PHONE NUMBER	DATE OF BIRTH

PATIENT ADDRESS

EMAIL ADDRESS (REQUIRED FOR ELECTRONIC DELIVERY)

I HEREBY AUTHORIZE THE FACILITY NAMED ABOVE TO DISCLOSE "PROTECTED HEALTH INFORMATION" TO:

PERSON/ORGANIZATION/ PROVIDER NAME_____

ADDRESS_____

INFORMATION AUTHORIZED TO BE DISCLOSED

❑ **ELECTRONIC DELIVERY** ❑ **PAPER COPY**

- ❑ All medical records used for treatment by facility
- ❑ Billing Records: ❑ UB-04 ❑ Itemized Statement
- ❑ Physician Progress Notes
- ❑ History & Physical
- ❑ Discharge Summary
- ❑ Designated Record Set (Medical & Billing Records)
- ❑ Physician Orders
- ❑ Nurses' notes
- ❑ Imaging/Radiology Reports
- ❑ Operative/Procedure Reports
- ❑ Lab/Test Results Only
- ❑ Other: _____

DATE(S) OF SERVICE REQUESTED: _____

PURPOSE/REASON FOR REQUEST:_____

UNLESS REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: _____

If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing.

- ❑ I understand that I may revoke or cancel this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation addressed to: HIM Department at: _____ and I also understand that any information/PHI released previous to this revocation or cancellation has been released in good faith and is now in the records of a healthcare entity or provider as previously authorized.
- ❑ I understand that PHI that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- ❑ I understand the Hospital is not responsible for any misuse/disclosure made by a third party to whom I have authorized release of my PHI.
- ❑ I understand that I have the right to request or inspect or copy my PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- ❑ I understand I need not sign this form to ensure healthcare treatment, payment, enrollment in my health plan, or eligibility for benefits.
- ❑ I understand that I do not have to provide a reason for requesting release of my PHI.
- ❑ I understand that there may be charges for copying/sending these records. This will be discussed at the time I sign or turn in this request.
- ❑ I understand that under HIPAA Privacy, my access to PHI may be restricted if appropriate for my care and treatment.
- ❑ I understand that I will be given a copy of this authorization form, after signing.

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition, **other than notes recorded by a mental health professional documenting or analyzing conversation during a counseling session provided such notes are maintained separately** (unless this authorization pertains specifically to psychotherapy notes); information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to state and federal laws and regulations.
By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization as stated above. **INITIALS:**_____

_____ _____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Print Name of Patient or Personal Representative **Description of Personal Representative's Authority/Relationship**