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McLeod Health

The Choice for Medical Excellence

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Created 2003 Reviewed 12-04-2018 Revised 12-07-2018

Patient Name: _____ Date of Birth: _____

Address: _____ SS#: _____

_____ Patient # or MR#: _____

I authorize McLeod Regional Medical Center (Provider) to use or disclose my "protected health information" (PHI) to:

Recipient Name	Address	City	State	Zip

Information for treatment period: From (date) _____ To (date) _____

☐ Discharge Summary ☐ History and Physical Examination ☐ Consultation

☐ Pathology Reports ☐ Laboratory Tests ☐ Radiology Reports

☐ Operative Notes ☐ Emergency Department Reports

☐ Other (please specify): _____

Purpose(s): ☐ Legal Investigation ☐ Insurance ☐ Disability Determination ☐ Other _____

OR: ☐ I request my information be released to me to exercise my right to access and obtain a copy of my PHI.

A.) I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.

B.) I understand the PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS or HIV).

C.) I understand I may revoke this Authorization at any time however the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Privacy Official to initiate the revocation process.

D.) I understand that McLeod Health will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on where I provide authorization for the requested to use or disclosure.

E.) I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.

F.) I understand that this Authorization will expire in 90 days after it is signed unless another date is specified here _____.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release the Provider (as named above) from any liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this Authorization.

_____ _____

_____

Print Patient Name Patient Signature Date

_____ _____

_____

Authorized Representative Relationship to Patient Telephone Number

PROVIDER USE ONLY: Received on _____ Disclosure on _____ Copy to Patient on _____

Disclosure by: _____ Authority: _____