THE RICHLAND HOSPITAL
and Clinics

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____ Date of birth: _____

Previous Name(s): _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

HEALTH INFORMATION RELEASED **FROM:** (**Who** has the information you want released?)

❑ The Richland Hospital and Clinics or

❑ Other person/organization: _____

Attn/department: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

HEALTH INFORMATION RELEASED **TO:** (**Where** do you want the information sent?)

❑ The Richland Hospital and Clinics or

❑ Other person/organization: _____

Attn/department: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

HEALTH INFORMATION TO BE RELEASED: (**What** information do you want sent or released? Check the appropriate boxes.)

Indicate date(s) of service: _____

❑ Routine record sets ❑ Clinic encounter(s) ❑ Hospital encounter(s)

Send CHECKED Records only:

❑ Discharge summary ❑ Radiology reports ❑ Medication/allergy record

❑ Operative report ❑ Laboratory reports ❑ Immunizations

❑ History & physical ❑ Pathology reports ❑ Billing records

❑ Emergency records ❑ Diagnostic test results ❑ Copies of films/images

❑ Progress notes ❑ Rehab records ❑ (PT/OT/ST)

Other: _____

Continued on other side →

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All records pertaining to behavioral/mental health, HIV/HIV related illness, and alcohol and/or drug abuse will not be released unless indicated here.

❑ Behavioral/mental health ❑ HIV/HIV-related illness ❑ Alcohol and/or drug abuse

PURPOSE OF DISCLOSURE: (**Why** is it needed?)

❑ Continuity/transfer of care ❑ Personal use or review ❑ Changing clinics
❑ Referral ❑ Insurance or disability determination ❑ Dissatisfied with care
❑ Legal/attorney ❑ Moving out of area
❑ Other:_____

RELEASE INSTRUCTIONS: (**How** and **When** do you want the information?)

Date information is needed: _____***(NOTE: Please allow 7 business days for processing.)***

Delivery/format method:

❑ Mail – paper ❑ Pick up – paper ❑ Fax – paper
❑ Mail – CD (only for imaging) ❑ Pick up – CD (only for imaging)
❑ Richland Hospital and Clinics' Health Portal
❑ Other:_____

I HAVE READ AND UNDERSTAND THE FOLLOWING RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
- I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. To do so, I may contact The Richland Hospital and Clinics' privacy officer.
- I understand that I am under no obligation to sign this form; however, if I agree to sign this authorization, I can be provided with a signed copy of the form upon request.
- I have the right to withdraw this authorization at any time by contacting The Richland Hospital and Clinics' privacy officer in writing. My withdrawal will not be effective as to uses and/or disclosures that The Richland Hospital and Clinics (TRHC) has already made in reference to this authorization.
- I understand that I am under no obligation to sign this form and that TRHC may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this form.
- TRHC cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release TRHC from any and all liability resulting from a redisclosure by the recipient.
- I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am authorizing TRHC to disclose my above identified protected health information.

SIGNATURE REQUIREMENTS:

_____ _____

Patient/Legal Representative's signature *(include relationship if other than patient)* Date

OFFICIAL USE ONLY: Completion date: _____Clinic/nursing staff (Initials): _____

ROI/HIM staff (Initials): _____Photo ID:_____