HARBOR BEACH COMMUNITY HOSPITAL

PATIENT STICKER

## Authorization For Release of Patient Health Information

**(PATIENT NAME)** **(DATE OF BIRTH)** **(TELEPHONE)**

**(ADDRESS)** **(CITY)** **(STATE)** **(ZIP)**

**I hereby authorize** _____ **to use or disclose the following protected health information for**

**services rendered on**_____ **to** ☐**Myself** ☐**Other:**_____.
**Print the name of who the information should be released to (physician, insurance co., attorney, etc.)**

☐ Entire medical record
☐ History/Physical
☐ Surgical report
☐ Emergency room report
☐ Consultation records
☐ Discharge summary
☐ OTHER (PLEASE SPECIFY): _____

☐ Outpatient procedure
☐ Walk In Clinic chart
☐ Laboratory/Pathology report
☐ EKG
☐ Billing records
☐ Radiology report

**HIMS Use Only**
Received:_____
Complete:_____
ROI Log#_____
Account#_____

**PURPOSE OF RELEASE:**_____

**I WOULD LIKE TO RECEIVE THE ABOVE INFORMATION IN THE FOLLOWING FORMAT: ___Mailed ___Faxed ___Pick Up ___CD ___Encrypted electronic media _____(email address) Other_____(explain)**

The records listed below are protected by Federal Law. If you want this information included with this release, please initial only the items to be included.

_____Alcohol and/or drug abuse, mental health, psychological services, social services

_____Information concerning Human Immunodeficiency Virus (HIV) test results, Acquired Immunodeficiency Disease (AIDS) or related diseases such as Communicable diseases and infections.

**I AM REQUESTING THAT MY HEALTH INFORMATION BE DISCLOSED TO:**

NAME OR ENTITY (PHONE/FAX NUMBER)

(MAILING ADDRESS) (CITY/STATE/ZIP)

**SIGNATURE OF REQUESTOR**: _____ **DATE**: _____
(Patient/Parent/Guardian/Authorized Representative)

This authorization expires within (60) days from the date this authorization is signed. I may revoke this authorization at any time by notifying Harbor Beach Community Hospital Health Information Management Services in writing, but if I do, it will not have any effect on any actions taken before the revocation was received. There might be exceptions to revoke this authorization, please read your Notice of Privacy Practices to discover your revocation rights and exceptions to revocation. Treatment, payment, enrollment or eligibility for benefits are not a condition of a signature of this authorization. I understand that any disclosure of information carriers with it the potential for an unauthorized redisclosure. Redisclosed protected health information, once released as requested from the hospital, will no longer be protected by HIPAA (Health Information Portability Accountability Act) including paper, facsimiles, or electronic media. I understand mailing paper medical records through the U.S. Postal Service includes the risk of loss or theft of the documents. By signing below, I release Harbor Beach Community Hospital of any and all responsibilities regarding loss or theft of any mailed documents included in this request.

**Legally Authorized Signature**: _____ Relationship_____ Today's Date_____

Driver's License#_____ *Copies were released on*_____
*Released by (Initials)*_____

WITNESS:_____ Today's Date_____