Authorization for Use or Disclosure of Protected Health Information

Name of Resident: _____ Date: _____

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I hereby authorize the release of the information checked and/or listed below for the time period beginning on _____ and ending on _____:

[ ] Complete health care record(s)
[ ] History & Physical Examination
[ ] Minimum Data Set
[ ] Laboratory Reports
[ ] Medical / Treatment Records
[ ] Pathology Reports
[ ] X-Ray Reports
[ ] Transcribed Reports
[ ] Nurses' Notes
[ ] Discharge Summary
[ ] Progress Notes
[ ] Care Plans
[ ] Dental Records
[ ] Photographs, Video Tapes, Digital, or other images
[ ] Billing Statements
[ ] Emergency Care Records
[ ] Consultant Reports
[ ] Other: _____
[ ] Other: _____
[ ] Other: _____

The information checked and/or listed above is to be released to: _____
for the purpose(s) of _____
_____ .

I understand that the individual, organization, or entity receiving my health information may receive financial or in-kind compensation in exchange for using or disclosing the information described above.

Unless otherwise revoked by me, I understand that this authorization will expire on _____ or upon the completion of the use of the information for the purpose it was intended, whichever is earlier.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release the facility, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at anytime by providing the facility with my written notice of such revocation.

Date: _____ Signature of Resident: _____
Printed Name of Resident: _____

Date: _____ Signature of Representative: _____
Printed Name of Representative: _____
Relationship to Resident: _____

Date: _____ Signature of Witness: _____
Printed Name of Witness: _____

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.