CCMC AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

Patient Name: ______________________________ ________________ ________________
Date of Birth **Medical Record**

1. **I hereby authorize** ______________________________ **to:** ___ **obtain my information from OR** ___ **release my information to:**

____ ________________
Telephone/Fax Number

Address: ____

2. **Information to be released:** **Only the period or events from:** __________ **to:** ________________

___ **ALL CCMC MEDICAL RECORDS (Excluding limitation records) or the SELECTED RECORDS;**

___ History and Physical Examination ___ Discharge Summary ___ Physician's Orders
___ Nursing Notes ___ Emergency Room Report ___ Operative Report(s)
___ Physician Notes ___ Clinic Notes ___ Laboratory Data
___ Pathology Report(s) ___ Radiology Report/X-Ray Films ___ EKG/Cardiology Report
___ Consultation by Dr.______________________________
___ Other-specify: ____

3. **There are no limitations** placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health, behavioral or psychiatric treatment.
SIGNER MUST INITIAL THIS CLAUSE: ________ **OR QUALIFY THE ABOVE:** ________________

4. **The above information is released for the following purpose and that purpose only:**

___ Continuation of Care ___ Legal Purposes ___ Insurance Purposes ___ Employer Requirement
___ Personal Reasons ___ Other: ____

5. **Revocation Process:** I understand that I may, by placing my request in writing to the Privacy Officer, revoke this Authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy. This Authorization will expire three months from the date of my signature or as otherwise specified by date, event or condition as follows: ____________________________.

6. **Right to Copy/Voluntary Disclosure:** I know that I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

7. **Health Plan/Insurance Issuers-Conditions:** I need not sign this form in order to receive treatment, to have my treatment paid for by my insurer, for enrollment in a health plan or eligibility for its benefits. If I am authorizing my information to be released to an insurance company, I have been advised by my insurer of my rights and the consequence to me should I refuse to sign this Authorization.

8. **Photocopy:** I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization, may deny the release of protected health information, if it has reason to believe (1) this authorization has been altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested.

____ ________________________
Patient's Signature (Photo identification may be required) Date (Must be within 90 days)

____ ________________________
Signature of Other Individual if under the age of 18 Relationship to Patient

Attach Document to Prove Authority to Act on behalf of Patient REDISCLOSURE: I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by Federal confidentiality rules.
SIGNER MUST INITIAL THIS CLAUSE: ________
PROHIBITION OF REDISCLOSURE: Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical information is not sufficient for this purpose.

Information has been released per authorization by ______________________________ on date: ____________

PLEASE FAX TO (907) 424-8406 ATT: MEDICAL RECORDS Updated November 18, 2010