CORDOVA COMMUNITY MEDICAL CENTER (CCMC) AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____ MR # _____

1. I hereby authorize CCMC to _____ Obtain my information from
_____ Release my information to

NAME _____ TELEPHONE/FAX _____

ADDRESS _____

For the purpose of:

_____ Continuation of care _____ Insurance purposes _____ Legal review
_____ Personal reasons _____ Employer requirement _____ Other (please specify) _____

2. I limit the information to be released to the following items:

_____ All medical records (excluding limitation records) Covering records from on/about (date) _____ To (date) _____

_____ History & physical exams _____ Discharge summary _____ Physician's orders
_____ Nursing notes _____ Emergency room report _____ Operative report(s)
_____ Physician notes _____ Clinic notes _____ Laboratory data
_____ Pathology reports _____ Radiology report/xray films/CT _____ EKG/Cardiology report
_____ Consult by Dr. _____ _____ Other (please 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 _____ Or qualify above _____

4. Revocation Process: I understand that I may, by placing my request in writing to the HIM, 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: _____.

5. 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.

6. 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.

7. 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 id may be required) Date (Must be within 90 days)

_____ _____
Signature of other individual if under age 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 _____ Medical Records (907) 424-8406 _____ Clinic Nurse (907) 424-8202 Updated 5/5/2016