HANSEN FAMILY HOSPITAL AND AFFILIATED CLINICS
Authorization to Release Protected Health Information

I understand that if the person(s) and or organizations(s) listed below are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standard, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards, and my health information may be re-disclosed without obtaining my authorization.

This authorization will automatically expire one year from date of signature or until _____, 20___. This authorization applies to past, present, and future health records. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on the actions they took before they received the revocation.

Any refusal to sign this form will not affect my ability to obtain treatment, payment or my eligibility for benefits. I may request to inspect or copy the health information to be used or disclosed. This release is not valid if it does not contain the patient signature.

Patient Information:

_____ _____ _____
Name Date of Birth Medical Record Number

_____
Previous Name

_____
Street Address City State Zip Code

_____
Daytime Phone Number

CHECK METHOD FOR DISTRIBUTION OF RECORDS

Release Information From:

_____
Name Department

_____
Street Address/P.O. Box

_____
City, State, Zip Code

_____
Phone Number Fax Number

Send Information To: Upcoming appt. date _____

☐ _____
Name Department

_____
Street Address/P.O. Box

_____
City, State, Zip Code

_____ ☐_____
Phone Number Fax Number

☐ Pick-up ☐ Email _____
Email Address

Medical Information to be released:

___ Office Notes (this will be limited to 2 years of information including lab and x-ray, unless otherwise specified)

___ Lab/Pathology ___ X-Ray Reports/Films ___ Mental Health ___ OB Flow Sheet ___ Therapy

___ Mammo Films ___ Mammo Reports ___ Immunizations ___ Cardiovascular ___ ER ___ Hospital

___ Billing Information ___ Specify _____

For date(s) of treatment or condition _____

The information disclosed may include matters regarding mental health/depression, alcohol or drug abuse, infectious diseases, including HIV and genetic testing information. Refusal to consent to release information will result in such confidential records not being released. If you do not wish such information to be released, state information to be excluded: _____

I am requesting this information to be released for the following purpose:

___ Medical Treatment ___ Transfer of Care ___ Worker's Compensation ___ Insurance ___ Disability

___ At My Request ___Legal ___ Moving ___ Other

A copy of this signed form will be provided to the patient.

_____ _____
Signature of Patient or Legal Representative **Date** **Witness**

Relationship, if not patient _____. Legal documentation is required supporting his/her authority to act on a patient's behalf. Photo identification will be requested for all hand carry release of information requests. Facsimile reproductions of the signature are acceptable. Our facility may charge a fee for this service.

For Facility Use

ID Verification by: Initials _____ Date _____

Information to be: ☐ mailed ☐ faxed ☐ picked up Disk created by: _____ Date:_____

☐ *Patient transfer* *Disk given to:* _____

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