RELEASE OF INFORMATION

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Date ______________________________ Pt ID: ______________________________ Acct # ______________________________

Last Name: ______________________________ First: ______________________________ MI: __________ Date of Birth: __________

Patient Address: ______________________________ Patient Phone: ______________________________

Requestor's Name: ______________________________ Requestor's Address: ______________________________

Requestor's Phone: ______________________________ Requestor's Fax: ______________________________

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL: ____________________(Date)

PURPOSE OF DISCLOSURE:

- o Legal services
- o Processing of my insurance claim
- o Treatment in the facility indicated above
- o Application of insurance or state/federal funding programs
- o Other: ____

I specifically authorize the use and/or disclosure of the following highly confidential information: Mental health, HIV results, AIDS information, sexually transmitted diseases, alcohol or drug abuse, sexual assault and/or child/adult abuse and/or neglect.
Signature: ____

SPECIFY INFORMATION TO BE DISCLOSED:

- o History & Physical
- o Operative Report
- o Lab Reports
- o Pathology Report
- o X-ray Reports
- o X-ray Film
- o Consultation Report
- o Other: ______________________________

I UNDERSTAND THAT:

- I have the right to revoke this authorization for any reason and this revocation will not apply to information that has already been released in response to his/her authorization.
- If I revoke this authorization, I must do so in writing and present my written revocation to the health information management department.
- I can refuse to sign this authorization.
- Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
- Authorizing the disclosure of my health information is voluntary.
- I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if requested.

I authorize Capitol Imaging Services or a member of its staff to discuss my health condition, plan of treatment, medical bills or other health information from my medical records with the individual listed below.

Name: ____ **Phone #:** ______________________________

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED:

Signature of Patient/Guardian/Representative ______________________________ **Date** ______________________________

Print name of Patient/Guardian/Representative ______________________________ **Relation of Patient** ______________________________

For Internal Use Only

Records released by: Fax: ____Mail: ____Patient: ____ Other: ______________________________

Signature of staff releasing information: ____

Validity of Requestor: Driver's license:_____ Passport:_____ Comparison of signatures documented in the PHI Records:_____
Request faxed on requestor's letterhead:_____