AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient:_________________________________ Date of Birth:__________________ Medical Record #:_____________

I hereby authorize ____
(Name and address of Individual or Organization)

to release to ____
(Name and address of Individual or Organization to receive information)

the following information from my medical record for the time period: ____.

_____ Cedar Mountain Center
_____ Clinical Resume/Discharge Summary
_____ History & Physical Report
_____ Consultation Report
_____ Emergency Room Report
_____ Urgent Care Report
_____ Operative/Procedure Report

_____ Long Term Care Center
_____ Pathology Report
_____ Laboratory Report
_____ Direct Access Lab
_____Radiology Report
_____ Radiology Image (PACS)
_____ EKG Report

_____ Rehab(PT/OT)
_____ PFS (Billing)
Other (Specifiy) ______
____
____

For Internal use by West Park Hospital Staff
Completed By:

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL, AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.
I specifically authorize the release of the following records:

☐ Psychiatric/Psychological ________ Initials ☐ HIV ________ Initials ☐ Drug and/or Alcohol Dependency _________ Initials

The information is necessary for the following purpose:

_____Diagnosis & Treatment _____ Legal _____ Personal: ____________________________________
_____ Insurance/Billing _____ Military _____ Other: ______________________________________

This authorization shall remain in effect until the following date, event or condition: _______________________________________
If no date, event or condition is specified, this authorization will expire in one (1) year.

1. This authorization remains in effect until the above date, event or condition, unless specifically revoked by written notice to the individual or organization. I understand that this may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality.
2. I understand that authorizing the disclosure of this heath information if voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that received the information is not a health care Provider or health plan covered by deferral privacy regulations, the information described above may be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

____ ________________________________ ____________
Signature of Patient or Legal Representative Relationship Date

____
(If patient is unable to sign, please state reason.)

☐ **CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING CHEMICAL DEPENDENCY RECORDS** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibits you from making any further disclosure of it without the specified written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose.