CATHOLIC Medical CENTER

Authorization to Release or Request Protected Health Information

Full Name: _____ Date of Birth: _____

AUTHORIZATION TO: (Check One)

☐ Release Patient Information to: _____

Street: _____ City/State:_____

☐ Request Patient Information from:_____

Street: _____ City/State:_____

PATIENT INFORMATION to be released or received: (Check One) ☐ **Pick-up: _____**

Date(s) of Service: _____ to _____ ☐ **Mail**

☐ **Fax**(to other healthcare providers only)

Type of Information: (Check One)

☐ ER ☐ X-Ray ☐ History& Physical ☐ Discharge Summary

☐ Consult ☐ Lab ☐ Operative Report ☐ Progress Notes

☐ Other: _____

PURPOSE for which this information is being requested/ released: (Check One)

☐ Continued Medical Care ☐ Other: _____

The information authorized for disclosure may relate to: (initial all that apply)

_____ Behavioral Health _____ HIV/AIDS related illness _____ Drug or alcohol treatment

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that Catholic Medical Center shall not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- I understand that this authorization may be revoked in writing and the written revocation must be delivered to the Medical Records Department, revocation will not be effective for the disclosure of records whose release I had previously authorized, or where other action had been taken in reliance on a valid authorization.
- I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that Catholic Medical Center shall have the opportunity to obtain direct or indirect remuneration from a third party as a result of this authorization.

_____ _____ _____

Date Signature of individual or representative Relationship of representative

* * * * * *

EXPIRATION DATE: This authorization will expire on (date no later than one year from now) _____.
(If no date is stated, this authorization expires six months from the date it was signed.)

☐ COPY PROVIDED: Catholic Medical Center shall provide a copy of this authorization, when signed to the subject individual. **This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.**