Dimensions Healthcare System

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Birthdate: _____

Address _____ SS #: _____

Place Patient Label Here

_____ M.R.#: _____

I hereby authorize (***Hospital/Program***) _____ to release to

(***Complete name and address***): _____

the following:

The extent or nature of information to be released is indicated below:

☐ Inpatient care on _____ (Date of service)

☐ Emergency care on _____ (Date of service)

☐ Ambulatory/Outpatient care on _____ (Date of service)

☐ Complete medical record ☐ X-rays/Imaging Studies ☐ Abstract

☐ Laboratory Reports ☐ Discharge Summary ☐ Medication Sheets

☐ Operative Report ☐ Other (**Specify**):_____

I ☐ do ☐ do not wish to have information about HIV/AIDS released under this authorization.

I ☐ do ☐ do not wish to have mental health records released under this authorization.

I ☐ do ☐ do not wish to have information about drug/alcohol abuse treatment released under this authorization

The purpose for release of the above information is indicated below:

☐ Continued Care ☐ Insurance ☐ Legal ☐ Other ***(Specify)*****:** _____

☐ At my request ***(Patient only)***

DIMENSIONS HEALTHCARE SYSTEM

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to the hospital. This consent will expire in one year from date signed, unless otherwise stated as follows:_____. Each request for release of protected health information requires a separate authorization.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____

Signature of Patient **Date signed**

_____ _____

Signature of Parent, Guardian, or Legal Representative **Witness**

If signed by other than patient, state relationship and reason for patient's inability to sign.

_____

_____

_____

Verbal consent requires signature of two witnesses:

_____ _____

Signature of Witness **Date**

_____ _____

Signature of Witness **Date**

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act.

A copy of this authorization has been ☐ accepted ☐ rejected by the patient/representative.

DIMENSIONS HEALTHCARE SYSTEM