Meritus Health

AUTHORIZATION FOR RELEASE OF PATIENT IDENTIFIABLE HEALTH INFORMATION

Date of Request_____ Medical Record Number_____

I hereby authorize Meritus Medical Center to release to:

_____
(Physician, Hospital, Attorney, Insurance Company, self, etc)

_____
(Address, City, State, Zip code) (Phone Number)

The following health information from the medical records of:

_____
Patient Name Date of Birth Social Security Number

Information to be disclosed is from the following time(s)

- ☐ Inpatient, Dates of Stay _____
- ☐ Outpatient Date(s)_____
- ☐ Emergency Department Date(s)_____

Specific Information to be disclosed:

☐ Entire Record ☐ Other (specify)_____
☐ Test Results (specify)_____ ☐ Limitations (specify)_____
☐ Most Recent History & Physical, Discharge Summary, Operative Report(s), and Consultation(s)

This health information is needed for:

☐ Personal Use ☐ Continuing Medical Care ☐ School ☐ Insurance
☐ Legal Reasons ☐ Social Security/Disability ☐ Military ☐ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about history, diagnoses and or treatment of drug or alcohol abuse, mental illness, or communicable disease. I authorize the disclosure of this specific information. I also understand that the person giving authorization may revoke this authorization by a written and dated notice to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it. I understand that I may be charged for copies of my health information.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

I understand authorizing the use or disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient Date Signature of Parent/Executor/Legal Representative Date

_____ _____
Witness Date Witness Date

12/03/10