Authorization to Use and Disclose Protected Health Information

Authorization to release the protected health information of:	
Patient Name:	MRN (office use Only):
Current Address: City: State: Zip:	
Phone Number: ( )	Date of Birth: / /
This authorization is to release the protected health information to:	
Name:	Phone Number: ( )
Address: City: State: Zip:	
Deliver by: ☐ In Person ☐ Mail ☐ By Phone ☐ Fax — Fax Number: ( ) ☐ Secure Email — Email Address:	
This authorization is to release the protected health information from:	
Facility Name/Provider:	Phone Number: ( )
Address:	Fax Number: ( )
The purpose of this disclosure is:	
Dates of service requested:	

Release the following information:

Patient Health Information:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report(s)
- ☐ Consultations
- ☐ Treatment Plan(s)
- ☐ Other Protected Health Information as specified:
- ☐ Pathology Report(s)
- ☐ Radiology Report(s)
- ☐ Lab Report(s)
- ☐ Progress Notes

Financial:

- ☐ Itemized Billing Statement
- ☐ Financial Information

This Authorization will remain in effect:

☐ From the date of this Authorization or until the following event occurs:_____

Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.

I understand that:

- Once *"this facility"* discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to *"this facility"* to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR § 164.524.
- This Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to Ridgeview Family Health. If I revoke this Authorization, Ridgeview Family Health may not be able to reverse the use of disclosure of my health information while the Authorization was in effect.
- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of *"this facility"* treatment of me, enrollment in the health plan, or eligibility for benefits.
- If I have questions about disclosure of my health information, I can contact Ridgeview Family Health.
- Si lo solicita, se le proveerá un servicio de interpretación gratis. Hable con un empleado del hospital para solicitarlo.

Signature of Patient or Personal Representative:	Date:
If Signed by Personal Representative, Relationship:	Signature of Witness (optional):