Sarah Bush Lincoln

DATE RECEIVED: _____ Medical Record #: _____ Encounter #: _____

DATE STARTED: _____

AUTHORIZATION EXPIRATION DATE: _____ **(see last paragraph below)**

1. FROM: ☐ Health Center ☐ Home Care ☐ Home Medical Equipment
☐ Physician Clinic: _____ ☐ Hospice ☐ Other: _____
☐ SBL Dental Services

2. **You are hereby authorized to release protected health information to:** *(Who the protected health information is going to)*

_____
(Name of Party to Receive Protected Health Information)

_____ _____ _____ _____
(Address) (City) (State) (Zip Code)

3. **Release protected health information of:** _____ _____
(Name of Patient) (Birthdate)

_____ _____ _____ _____
(Address) (City) (State) (Zip Code)

4. The patient or authorized representative authorizes the use or disclosure of protected health information to be released. **Patient or authorized representative must initial the item, which needs additional protected health information disclosed.**
____ Abuse ____ Genetic Testing ____ Mental Health/Psychiatric
____ Alcohol and/or Drug Related ____ HIV/AIDS ____ Other: _____ ____ Reproductive Health

5. Date(s) of Care: from: _____ to: _____

6. **The Type of protected health information to be used or disclosed is as follows:**
☐ Diagnosis / Procedures ☐ Provider Progress Notes ☐ Entire Admission ☐ Imaging Reports ☐ EKG Reports
☐ History & Physical ☐ Discharge Summary ☐ Emergency Room Record ☐ Imaging Films
☐ Operative Report ☐ Pertinent Data ☐ Pathology Report ☐ Lab Reports
☐ Other (Specify) _____

7. **Method of release:** ☐ Photocopies ☐ FAX ☐ CD ☐ Film ☐ Encrypted Email _____
8. **For the purpose of:** ☐ Continued Treatment ☐ Legal ☐ Personal ☐ Other _____

The foregoing authorization was read, discussed, and signed in my presence. I am signing freely and with full knowledge and understanding. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that other health care provider records may be a part of my hospital record and I can release them as authorized. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by the Federal Health Information Privacy Regulations. The redisclosure of drug and alcohol abuse is generally prohibited in accordance with the confidentiality of alcohol and drug abuse patient record rules. I understand that I can contact these departments for questions about disclosures of my protected health information.

I further understand that a refusal to authorize the release of the above information will prevent the disclosure of the information without further authorization or when mandated by law. There is the right to revoke the authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insured with the right to contest a claim under my policy. **Unless otherwise revoked in writing, this authorization will expire 1 year from date signed.**

9. **Signed** _____ **Date / Time** _____
(Patient or Legal Representative)

If Legal Representative, document relationship to Patient: _____

Signed _____ **Date / Time** _____
(Witness)

For Office Use Only **Processed By:** _____ **Date:** _____ **Number of pages:** _____

Clinic Scan to: HIPAA Privacy Documents

AUTHORIZATION TO ACCESS and DISCLOSE PROTECTED HEALTH INFORMATION

HIP003