KIRBY MEDICAL CENTER

Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____

Mailing Address of Patient: _____ City: _____ State: ____ Zip: _____

Phone Number: _____ Last 4 digits of SSN: _____ MRN: _____

I authorize: ☐ Kirby Medical Group - Clinic Provider: _____ ☐ Kirby Medical Center - Hospital

☐ To Release to: _____
(Name of Health Care Facility, Individual, or Agency, etc.)

☐ To Request from: _____
(Address)

_____ _____ _____
(City, State, Zip) (Phone) (Fax)

Method of Release: ❑ Mail Pick up at: ❑ HIM Department ❑ Emergency Dept. Registration ❑ Fax

❑ Email to Patient Service Provided by ScanSTAT Email Address: _____

SPECIFIC RECORDS TO BE RELEASED:

CLINIC Dates: _____ to _____	**HOSPITAL** Dates: _____ to _____
❑ Record Abstract (last 2 years)	❑ ED Visit(s) ❑ Inpatient Hospitalization
❑ Immunization Record	❑ Immunization Record ❑ Abstract - H&P, Disc Sum, Progress Notes
❑ Mental Health (requires additional authorization form)	❑ Laboratory Report(s) ❑ Complete Stay
❑ Other _____	❑ Pathology ❑ Operative Report(s)
❑ Provider Notes	❑ Radiology ❑ Therapy Services
	❑ Reports ❑ CD Images ❑ Other _____

I specifically authorize the release of information relating to:

❑ **Substance abuse** (including alcohol/drug abuse treatment) ❑ **HIV-related** (HIV/AIDS-related testing) **& communicable disease(s) information**

❑ **Genetic Information** ❑ **Child Abuse/Neglect** ❑ **Abuse of Adult with a Disability** ❑ **Sexual Assault Treatment**

X _____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

The purpose of this disclosure of information is _____.
(i.e., continuing care, insurance claim, legal counsel, etc.)

A separate special authorization must be completed to release mental health records.

* I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
* I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (Ex: Pre-employment physical)
* I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously.
* This authorization will expire on the following date or event: _____. If I do not specify an expiration date or event, this authorization will expire in one year.
* I understand that I am entitled to a copy of this authorization.
* I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

* If the patient is 18 years of age or older, the patient must sign and date the form.
* If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

❑ Legal Guardian or Conservator ❑ Health Care Agent (Health Care Power of Attorney)

* If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

❑ Parent ❑ Legal Guardian

Signature: X _____ Date Signed: _____

Printed Name of Person Signing (if not patient): _____ Phone #: _____

STAFF USE ONLY

Reason for Verbal:

Verbal Authorization Given By: _____ *Verbal Obtained by Staff Name:* _____ ❑ *PHE* ❑ *Other:* _____
Name Relationship to Patient

Records Given to Patient by Staff Name: _____ *Type of ID Verified:* _____ *Date:* _____

❑ HIM ❑ Registration ❑ Clinic