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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM SHADY GROVE ADVENTIST HOSPITAL

Please Print Clearly

Name ____
Last First Initial

Address ____
Street City State zip code

Telephone ( ) ____________ Birth Date____________ Medical Record # ____________

I authorize Shady Grove Adventist Hospital to disclose the above named health information to:

Name of Doctor, Hospital, etc. ______________________________

Address ______________________________

City/State/Zip Code______________________________

The type and amount of information to be used or disclosed is as follows: (please check)

- ☐ H&P
- ☐ Labs
- ☐ Entire record
- ☐ Discharge Summary
- ☐ X-rays/X-Ray Films
- ☐ Specific information (please specify) ____________
- ☐ Progress Notes
- ☐ Billing Records

I give **special** permission to release any information regarding: (please check)

- ☐ Substance abuse
- ☐ HIV Information
- ☐ Psychiatric/Mental Health Information
- ☐ Psychological/Neuropsychological
- ☐ Psychotherapy

Reason for Disclosure/Dates of treatment for request: ______________________________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation 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 that 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. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Unless revoked this authorization will expire on the following date, event or condition ____________
If I fail to specify an expiration date, this authorization will automatically expire one year from the date signed. I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. If I have a question about disclosure of my health information, I can contact the HIM Director or Chief Privacy Officer.

Information that has been disclosed to you may be protected by Federal Confidentiality regulations (42 CFR Part 2). Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any patient receiving alcohol or drug abuse treatment.

Patient Signature ______________________________ Date ____________

Legal Representative ______________________________ Date ____________
(State Relationship)

Patient Identification

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