



AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____
Date of Birth _____
SSN _____

Medical Record Number (HUN) _____
Account Number _____
Phone Number _____

- 1. I authorize the use or release of the above named individual's health information as described below:
- 2. The following individual or organization is authorized to release information:

Address _____

3. The type and amount of information to be used or released is as follows: (include dates where appropriate)

- Emergency Department Record from (date) _____ to (date) _____
- Discharge Summary from (date) _____ to (date) _____
- History and Physical from (date) _____ to (date) _____
- Consultation from (date) _____ to (date) _____ from (doctors' name) _____
- All Consultations from (date) _____ to (date) _____
- Laboratory from (date) _____ to (date) _____
- Radiology from (date) _____ to (date) _____
- Operative Report from (date) _____ to (date) _____
- Pathology Report from (date) _____ to (date) _____
- Billing Information from (date) _____ to (date) _____
- Home Health Record from (date) _____ to (date) _____
- Rehab Records from (date) _____ to (date) _____
- Speech & Hearing Records from (date) _____ to (date) _____
- Entire Record from (date) _____ to (date) _____
- Other _____

4. 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 behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be released to and used by the following individual or organization:

Address: _____
for the purpose of: _____

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

7. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or released, as provided in 45 C.F.R. 164.524. I understand any release of information carries with it the potential for re-release by the recipient and once authorized to be released, the information may not be protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996. If I have questions about the release of my health information, I can contact MRMC's Director of Medical Records (352-402-5387)

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness