

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization must be signed by the patient. If the patient is under 18 years of age, legally incompetent, or is unable to sign, the parent or guardian must provide authorization.

Patient Name _____ Date of Birth _____
 Address _____ Soc. Sec. Number _____
 City _____ Phone number _____
 State _____ ZIP _____ Contact _____

I HEREBY AUTHORIZE THE WASHINGTON HOSPITAL TO: **RELEASE TO** OR **OBTAIN FROM**
 Party to release/receive the above named individual's health information:

Name _____
 Address _____
 City _____ State _____ ZIP _____

INFORMATION TO BE RELEASED/OBTAINED:

Date	Type of Admission	Records
_____	Inpatient	<input type="checkbox"/> Discharge Summary
_____	Emergency Dept.	<input type="checkbox"/> Operative Report
_____	Outpatient Surgery	<input type="checkbox"/> Medical Portion
_____	Outpatient Diagnostic	<input type="checkbox"/> Other (specify) _____

This information will be used for the following purpose: _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I may revoke this authorization at any time by submitting a *written* notice of revocation to the Medical Records Department of The Washington Hospital. I understand that this notice cannot be revoked if records have already been released.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I may refuse to sign this authorization. My refusal will not affect my treatment or payment for my care. The Hospital may receive compensation for the use or disclosure of this information.
- In the case of a minor child: I certify that no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.
- In the case of a deceased patient: I, the undersigned next of kin, certify that I assumed responsibility for the disposition of the body of the deceased. There has been no probate of the decedent's Estate and there is no intent to enter the Estate into probate.

 Signature of Patient or Personal Representative

 Date / Time

 Printed Name of Patient or Personal Representative (if applicable)

 Relationship to Patient

This authorization automatically expires 6 months from the date of the patient's or personal representative's signature.

FOR OFFICE USE ONLY

REQUEST TAKEN BY: _____ DATE: _____
 RECORDS RELEASED BY: _____ DATE: _____
 Identification verified by:
 Patient Known to Staff
 Photo ID Obtained
 Signature Checked

INFO SENT

FS	PR	OR	EK	OP
DS	PO	LB	NN	AB
HP	CO	XR	ER	CC
OT	_____	DATE	_____	INIT