



BSRMR50

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Patient's Full Legal Name)

(DOB)

(Day Phone #)

Address: _____ City: _____ State: _____ Zip: _____

I, AUTHORIZE: _____
(Name of Organization to Disclose Information)

To DISCLOSE THE FOLLOWING INFORMATION:

Date(s) of Service: _____

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Abstract of Record | <input type="checkbox"/> Anesthesia Record | <input type="checkbox"/> Operative Report | <input type="checkbox"/> MyChart Communication |
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> X-rays or Imaging Report | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> ED Record | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Other: _____ |

Person/Facility to Receive Information: _____

Disclosure Format (Paper is default if not marked):

- US Mail
 Electronic format: CD/DVD
 Radiology Film/CD
 MyChart
 eDelivery by Ciox (for patient's only) - email address: _____

Purpose of Disclosure:

- Physician
 Insurance
 Legal
 Other (Please specify): _____
 Disability Determination
 Personal
 Worker's Compensation

Authorization to Release Information:

- I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, 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.

Special Instructions: _____

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that 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. If I have questions about disclosure of my health information, I can contact the organization above disclosing the information.
- I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility. 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. Unless otherwise revoked, this authorization will expire 6 months from the date of signature.
- I understand that copying charges will be applied, according to the hospital policy.

Signature of Patient or Legal Representative _____

DATE/TIME

If signed by legal representative, relationship to patient: _____

DEPARTMENT USE ONLY

PROCESSED BY: _____

IDENTITY VERIFIED SIGNATURE VERIFIED