## Authorization to Release or Obtain Health Information

Patient Name: _____

Previous Name: _____ Date of Birth: _____ Phone: _____

1. I authorize Sharon Hospital to: [ ] **RELEASE** Protected Health Information TO
   [ ] **OBTAIN** Protected Health Information FROM
2. The information identified above may be used by or disclosed to the following individual or organization:
   Name: _____
   Address: _____
3. The type of information to be used or disclosed (check box): Date of Service: _____
   [ ] History and Physical [ ] Discharge Summary [ ] Cardiology Reports
   [ ] Operative Report [ ] Lab Results [ ] Radiology Reports
   [ ] Radiology CD/Films [ ] Emergency Room Record [ ] Physical/Speech/Occupational Therapy
   [ ] Other (Please describe):_____
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.
   _____ (patient/legal representative initials)
5. The information for which I am authorizing disclosure will be used for the following purpose:
   [ ] Personal [ ] Insurance [ ] Continuation of Care [ ] Legal [ ] Other (Please describe) _____
6. 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.
7. If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed. This authorization will expire on (insert date): _____
8. I understand that once the above information is disclosed, it may be disclosed again by the recipient and the information may not be protected by federal privacy laws or regulations.
9. I understand authorizing the use or disclosure of the information identified is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient or Legal Representative Date

Legal representative's relationship to patient: _____

_____ _____
Signature of Witness Date

Sharon HOSPITAL
HEALTHQUEST