

One team united in caring™
KNOX COMMUNITY HOSPITAL

1330 Coshocton Road • Mount Vernon, Ohio 43050

AUTHORIZATION FOR USES AND DISCLOSURES OF PATIENT INFORMATION

1. I _____ authorize _____

(Print Full Name)

(Sender)

(Hospital)

(Physician)

(Address)

Telephone Number)

to release my personal health information to _____

(Recipient: Physicians, Hospitals, Employer, Attorney, Insurance Companies, etc.)

(Address)

Telephone Number)

Patient Date of Birth: _____ SS#: _____ Prior Name (maiden) _____

2. The date(s) of service to be released is/are _____

The reports to be released are: (mark ✓) discharge summary radiology lab
 consult OP report other tests _____
 Other _____

3. What is the purpose for authorizing the use or disclosure of your personal health information?

4. If you are a representative of a patient, describe the scope of your authority to act on the patient's behalf:

*You will need to provide legal documentation to support your scope of authority to act on the patient's behalf.

5. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

6. As described in the Notice of Privacy Practices of Knox Community Hospital, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Knox Community Hospital in reliance on this authorization, by sending a written revocation to Privacy Officer, 1330 Coshocton Avenue Mount Vernon, Ohio 43050.

7. This Authorization will expire:

when this request is completed
 In _____ days (or a date)(not to exceed 365)
 when this claim/case is finalized
 when research is complete

8. I understand that:

- I am not required to sign this authorization but Knox Community Hospital may disclose my personal health information regardless in accordance to State and Federal Laws.
- By signing/not signing this authorization, my treatment/care at Knox Community Hospital is not effected.
- Knox Community Hospital may use/disclose my personal health information from research treatment/care to a third party upon signing this authorization.

Print patient name

Print name of patient representative (if applicable)

Signature of patient (or representative)

DATE

Witnessed signature

DATE

For hospital/facility use only

Record components authorized for use or disclosure:

- Discharge summary
- H&P
- Testing (specify) _____
- Operative report, progress notes & discharge summary
- Consultations
- Entire medical record
- Other components (specify) _____

How was info released:

- Telephone
- Fax
- Mail
- Pickup By Whom _____

Signature of Hospital representative releasing info

DATE OF RELEASE