Authorization to Use or Disclose Health Information

(For Use When Patient Authorizing Release of Information)

Patient Name: ______________________ Medical Record #: ______________

Date of Birth: ____________ Telephone Number: ______________

Address: ____
Street City State Zip

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:

☐ Knox Community Hospital ☐ Affiliated Services ______________

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

Date of Service: ____________ ☐ Emergency Room Report ☐ Radiological Report

☐ Radiological Images

☐ Discharge Summary ☐ Consultation (Circle One) CD or Film

☐ Laboratory Report ☐ Operative Report ☐ History & Physical Exam

☐ Medication/Allergy ☐ Entire Record ☐ 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 or drug abuse.

5. I understand health information in my record may contain documents from the other healthcare providers used in whole or in part by the hospital and affiliated clinical services.

6. The information identified above may be used by or disclosed to the following individual or organization:

Name: ______________________ Fax/ Telephone (____) __________

Address: ____
Street City State Zip

7. This information that I am authorizing disclosure will be used for the following purposes:

☐ my personal records ☐ other healthcare provider ☐ Other ______________

8. I understand that I have a 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.

9. This authorization will expire:

☐ when this request is completed ☐ In ____ days, not to exceed 365 ☐ when claim/case is final

10. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

11. I understand authorizing the use or disclosure of the information identified above is voluntary. Signing this form has no impact on healthcare treatment.

12. I understand that part or all of my request for access to my health information may be denied if state or federal laws apply to certain circumstances. **(Please read back for reasons prohibited by law)**

______________________________ ______________
Signature of **patient** or legal representative Date

If signed by legal representative, relationship to patient (i.e. guardian, power-of-attorney, executor) *Provide supporting documentation.*

______________________________ ______________
Signature of **witness** Date

Copies of the authorization are available upon request.

Knox Community HOSPITAL

Please Read:

You need to know that we are permitted by law to deny part or all of your request for access for one or more of the following reasons:

- If your access request is not signed by you or your representative
- If your access request is signed by your representative and the representative has not provided information to us on the source of his/her authority to act for you.
- We may not maintain the information you have requested to copy or inspect
- If the information you have requested is not part of your records.
- If your request is for psychotherapy notes
- If your request includes information compiled for litigation
- If your request included information held by our laboratory that is not accessible by law
- If your request includes information created or obtained in the course of research still in progress that includes your treatment and you agreed to this denial of access when consenting to participate in the research;
- If a licensed health professional has determined that the requested access is likely to either endanger your or another person's health or safety or cause substantial harm to you or another person.
- If your request is to copy information and you are an inmate in a correctional facility (you retain the right to inspect the information)
- If your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.

For Hospital/Facility Use Only

Record components authorized for use or disclosure

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Laboratory Tests
- ☐ Radiology Tests
- ☐ Films
- ☐ CD's
- ☐ Operative Reports
- ☐ Consultation
- ☐ Entire Medical Record
- ☐ Other Components (please specify) ____________________

List Acct (#'s) ____________________
____
____
____

Indicate How The Information Was Released:

- ☐ Patient pick up
- ☐ Telephone
- ☐ Fax
- ☐ US Mail
- ☐ Federal Express Tracking # ____________________
- ☐ Other Describe ____________________

Was the patient offered a Privacy Notice? YES NO (Circle One)

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Signature of Hospital Representative Releasing Health Information Date of Release