Acct#_____ MR# _____

HOLZER HEALTH SYSTEM
AUTHORIZATION FORM FOR USES AND DISCLOSURES OF PATIENT INFORMATION

(740) 446-5363 Phone (740) 446-5310 Fax

I, _____, _____ hereby authorize the release of my
Patient Name DOB
protected health information (PHI) from and to the parties named below.

Releasing Facility:
Name: _____
Address: _____
City,State,Zip: _____
Phone/Fax: _____

Receiving Facility:
Name: _____
Address: _____
City,State,Zip:_____
Phone/Fax: _____

I authorize the release of the following PHI for the date(s) of service: _____
(Check all that apply)

- ☐ History & Physical
- ☐ D/C Summary
- ☐ Consultations
- ☐ OP/Procedure/Path
- ☐ Clinic Visit Notes
- ☐ Medication Administration
- ☐ Emergency Dept/Urgent Care
- ☐ All Test Results
- ☐ Radiology Films/Disc
- ☐ Entire Record for date(s) listed
- ☐ Orders
- ☐ CCD
- ☐ Progress Notes (CM/Provider)
- ☐ Clinical Assessments/ Nurse Notes
- ☐ Other: _____

I wish to **EXCLUDE** this information from release: ☐ Substance Use Disorder Treatment (SUD) ☐ HIV/AIDs
☐ Psychiatric diagnosis & treatment records ☐ Behavioral Health Notes ☐ Other_____

The purpose for this disclosure is: ☐ Continuity of Care ☐ Attorney/Court ☐ Personal Review ☐ Insurance
☐ Other_____

I understand the following:

- ☒ My health record(s) will not be released or obtained unless permission is provided for herein as evidenced by the signature on this Authorization
- ☒ The release of my health record(s) will be for the purpose stated on this form, and only those items checked off will be released.
- ☒ My SUD treatment records are protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the releasing or receiving entities from making any further disclosure of this information without my explicit written authorization or as otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of the SUD information to criminally investigate or prosecute any SUD patient.
- ☒ Information concerning drug related conditions, alcoholism, blood alcohol levels, toxicology screening, psychological and psychiatric conditions as well as information containing HIV, AIDS testing/diagnosis or related conditions will be released if applicable **unless specifically EXCLUDED from release in the exclusion section above**.
- ☒ The information used or disclosed pursuant to the Authorization (excluding SUD treatment records) may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations from further disclosure.
- ☒ This Authorization is in effect for a period of **sixty (60) days** from the date of signature below.
- ☒ I have the right to revoke this Authorization by notifying the releasing entity in writing of my desire to revoke it. Revocation does not apply to records that have been released in good faith prior to receipt of the written revocation letter by Holzer Health System.
- ☒ I am entitled to a copy of this completed Authorization.
- ☒ A photocopy of this form is as valid as the original.
- ☒ Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining the authorization unless permitted by the Privacy Rule.

Patient Signature X _____ **Todays Date** _____

Other person legally authorized to give consent: _____
Authority to give consent**:** _____ Reason: _____
Witness: _____ Date: _____


ROI

Staff member who completed this request _____

Method _____

Rev. 5/04; 5/13, 08/17, 5/18, 4/20, 11/21
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