

Acct# \_\_\_\_\_

MR# \_\_\_\_\_

### AUTHORIZATION FORM FOR USES AND DISCLOSURES OF PATIENT INFORMATION

Holzer  
100 Jackson Pike  
Gallipolis, Ohio 45631  
(740) 446-5363  
(740) 446-5310

Holzer Gallipolis  
90 Jackson Pike  
Gallipolis, Ohio 45631  
(740) 446-5363  
(740) 446-5310

Holzer Medical Center-Jackson  
500 Burlington Road  
Jackson, Ohio 45640  
(740) 446-5363  
(740) 446-5310

I, \_\_\_\_\_, \_\_\_\_\_ hereby authorize the release  
PATIENT NAME DOB  
of my personal health information from and to the parties named below.

**Releasing Facility:**

Name: Holzer Health System  
Address: 100 Jackson Pike  
City,State,Zip: Gallipolis, Ohio 45631  
Phone/Fax: 740-446-5363/740-446-5310

**Receiving Facility:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City,State,Zip: \_\_\_\_\_  
Phone/Fax: \_\_\_\_\_

I authorize the release of the following PHI for the date(s) of service: \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Clinic Visit Notes               | <input type="checkbox"/> Abstract core set |
| <input type="checkbox"/> D/C Summary        | <input type="checkbox"/> Emergency Dept/Urgent Care       | <input type="checkbox"/> CCD               |
| <input type="checkbox"/> Consultations      | <input type="checkbox"/> All Test Results                 | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> OP/Procedure/Path  | <input type="checkbox"/> Radiology Films/Disc             | _____                                      |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Entire Record for date(s) listed | _____                                      |

I wish to EXCLUDE this information from release:

The purpose for this disclosure is:  Continuity of Care  Attorney/Court  Personal Review  Insurance  
 Other \_\_\_\_\_

**I understand the following:**

- That my health record(s) will not be released or obtained unless permission is provided for herein as evidenced by the signature on this Authorization
- That 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.
- That 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.
- That the information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations from further disclosure.
- That this Authorization is in effect for a period of 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.
- That I am entitled to a copy of this completed Authorization.
- That a photocopy of this form is as valid as the original.
- That 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: \_\_\_\_\_



Staff member who completed this request \_\_\_\_\_

Method \_\_\_\_\_

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08/17  
#76801