Acct#___________________________ MR# _______________________________

AUTHORIZATION FORM FOR USES AND DISCLOSURES OF PATIENT INFORMATION

Holzer	Holzer Gallipolis	Holzer Medical Center-Jackson
100 Jackson Pike	90 Jackson Pike	500 Burlington Road
Gallipolis, Ohio 45631	Gallipolis, Ohio 45631	Jackson, Ohio 45640
(740) 446-5361	(740) 446-5361	(740) 446-5361
(740) 441-3933	(740) 441-3933	(740) 441-3933

I, ____, _________ hereby authorize the release
PATIENT NAME DOB
of my personal health information 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: __________________________________

_____ History & Physical
_____ D/C Summary
_____ Consultations
_____ OP/Procedure/Path
_____ Progress Notes
_____ Clinic Visit Notes
_____ Emergency Dept/Urgent Care
_____ All Test Results
_____ Radiology Films/Disc
_____ Entire Record for date(s) listed
_____Abstract core set
_____CCD
_____Other
____
____

I wish to EXCLUDE this information from release:
____

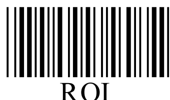
The purpose for this disclosure is: _____ Continuity of Care _____ Attorney/Court ____Personal Review _____Insurance _____Other_______________

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: __________________________


ROI

Staff member who completed this request
____

Rev 5/04, 5/13, 8/17, 5/18
#76801