

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: _____
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: _____

- | | | |
|---|---|--|
| <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, 5/18
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