Acct#_____ MR# _____

AUTHORIZATION FORM FOR USES AND DISCLOSURES OF PATIENT INFORMATION

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

Holzer Gallipolis
90 Jackson Pike
Gallipolis, Ohio 45631
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Holzer Medical Center-Jackson
500 Burlington Road
Jackson, Ohio 45640
(740) 446-5363 Phone
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I, _____, _____ hereby authorize the release
PATIENT NAME DOB
of my 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: _____

_____ 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 six (6) months 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 _____

Method _____

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