AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ DOB: ____________________
(Please Print)
SS#: ____________________

This will authorize: ☐ ____ **(specify)**
[Name or title of person(s) or organization(s)]

☐ **Frisbie Memorial Hospital**

to disclose my protected health information as described below:

☐ Discharge Summary ☐ Laboratory Data ☐ Radiology Reports
☐ H&PE ☐ E.D. Records ☐ Radiology Films
☐ Operative Note ☐ EKGs ☐ Vascular Lab Reports
☐ Consultation ☐ Nurses' Notes ☐ Cardiac Cath/Interventional Rad Reports
☐ Progress Notes ☐ PT/OT/ST ☐ Sleep Studies
☐ HIV/AIDS Related ☐ Abstract ☐ Pathology Reports
☐ Chemical Dependency Unit/Prospects Program ☐ Other (specify) ____________________

to: ☐ ____
[Name or title of person(s) or organization(s)]

☐ **Frisbie Memorial Hospital**

for the following purposes:

☐ Personal ☐ Legal ☐ Treatment (Continuation of Care)
☐ Insurance ☐ Other (Specify) ____________________

Dates of care included: ____________________ to ____________________

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that Frisbie Memorial Hospital shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- I understand that this authorization may be revoked in writing and delivered to the Medical Records Department of Frisbie Memorial Hospital at any time, although revocation will not affect the disclosure of records whose release I have previously authorized.
- I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient, and if so, may not be subject to federal or state law protecting its confidentiality.

______________________________ ____________________ ____________________
Patient's Signature **Relationship** **Date**
(Parent, Legal Guardian or Appropriate Consenting Party)

EXPIRATION DATE: THIS AUTHORIZATION WILL EXPIRE ON (DATE NO LATER THAN ONE YEAR FROM NOW) ______________________________

COPY PROVIDED: Frisbie Memorial Hospital shall provide a copy of this authorization, when signed to the subject individual.

This consent must be retained for 6 years.

WHITE - MEDICAL RECORDS DEPARTMENT PINK - PATIENT

Frisbie Memorial Hospital
It's about People. Technology. Trust.

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