

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Patient: (please print)	X Name: _____ X Social Security #: _____ X Date of Birth: _____										
Health Care Facility/ Provider:	WHO HAS INFORMATION YOU WOULD LIKE RELEASED? Name: _____ Address: _____ City: _____ State: _____ Zip: _____										
Requester:	TO WHOM SHOULD THE INFORMATION BE SENT? Name: _____ Address: _____ City: _____ State: _____ Zip: _____										
Information to be Disclosed:	<table border="0"> <tr> <td>_____ Hospital Reports</td> <td>_____ EKG Report</td> </tr> <tr> <td>_____ Lab Reports (recent)</td> <td>_____ Echocardiogram</td> </tr> <tr> <td>_____ Latest Clinic Visit Note</td> <td>_____ Stress Echo Report</td> </tr> <tr> <td>_____ Angiogram</td> <td>_____ Stress Test</td> </tr> <tr> <td>_____ Operative Report</td> <td>_____ Other: _____</td> </tr> </table>	_____ Hospital Reports	_____ EKG Report	_____ Lab Reports (recent)	_____ Echocardiogram	_____ Latest Clinic Visit Note	_____ Stress Echo Report	_____ Angiogram	_____ Stress Test	_____ Operative Report	_____ Other: _____
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_____ Operative Report	_____ Other: _____										
Extent of Information to be Sent:	<table border="0"> <tr> <td>_____ All Dates of Treatment</td> </tr> <tr> <td>_____ Dates of _____ through _____</td> </tr> <tr> <td>_____ Other: _____</td> </tr> </table>	_____ All Dates of Treatment	_____ Dates of _____ through _____	_____ Other: _____							
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Reason for Release:	<table border="0"> <tr> <td>_____ Insurance Coverage</td> <td>_____ Legal</td> </tr> <tr> <td>_____ Continuation of Care</td> <td>_____ Personal</td> </tr> <tr> <td>_____ Research</td> <td>_____ Other: _____</td> </tr> </table>	_____ Insurance Coverage	_____ Legal	_____ Continuation of Care	_____ Personal	_____ Research	_____ Other: _____				
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Revocation:	<p>I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information services department. I understand that the revocation will not apply to information that has been released in good faith. Unless otherwise revoked this authorization will expire one year from the date of signature.</p> <p>I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.</p> <p>I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization; I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure.</p>										

Patient's Signature: _____
 (Signature or mark of patient, parent or legal guardian)

Date: _____

Witness Signature: _____
 (Signature required if patient unable to sign and uses an "X")

Date: _____

* SPHCAUTHORIZATI ON *