Woman's

Medical Record Number _____

Authorization to Release Health Information from Woman's Hospital

Patient's Name X _____ Patient's Date of Birth x _____

I hereby authorize appropriate personnel at **WOMAN'S HOSPITAL** to release my health information to, and/or allow my records to be **reviewed by**:

Recipient(s):	x		
Recipient's Address:	x		
Attention:	x	**Contact Number:**	x

Purpose of Release

- ❑ for Treatment at Another Facility
- ❑ for Application for Insurance
- ❑ for Treatment by a Physician
- ❑ for Research
- ❑ for Processing of my Insurance Claim
- ❑ Personal (at my request)
- ❑ for an Interview
- ❑ for referral from GRACE program (care coordination for substance use disorder)
- ❑ for Publication, Broadcast, Online, Social Media or Other Dissemination by the hospital or media.
- ☑ Other Reasons; Specify:

Medical Clearance for release to participate

Specify information to be released by placing a check mark in the appropriate box(es):

Dates of Services

- ❑ Assessment Center Records
- ☑ Clinic Record
- ❑ Consultation Reports; Specify Doctor
- ❑ Demographic Information
- ❑ Diagnosis
- ❑ Discharge Summary
- ❑ Other Records; Specify
- ❑ Entire Record
- ❑ Entire Billing Record
- ❑ History & Physical
- ❑ Imaging Results
- ❑ Immunization Record
- ❑ Itemized Bill
- ❑ Lab Test Results
- ❑ Nurses Notes
- ❑ Operative Report
- ❑ Photograph/Video
- ❑ Physician Orders
- ❑ Physician Progress Notes

❑ _____

❑ Information Concerning Illness, surgery or events surrounding the birth of my child

Special consent is required to release the following information. Indicate Your Authorization by placing a checkmark in the appropriate box(es). NO INFORMATION WILL BE RELEASED IF BOX IS NOT CHECKED.

The following substance use disorder information: ❑ History & Physical ❑ Medications ❑ Demographics ❑ Diagnosis

❑ Discharge Summary and or Instructions ❑ Lab Results ❑ Orders (Physician/LIP) ❑ Progress Notes (Physician/LIP)

❑ Psychiatric Evaluation ❑ Treatment Plan

❑ Other; Please specify_____

❑ All Substance Use Disorder treatment records – (Includes all alcohol, drug or other substance use disorder records maintained by the provider/treatment program, relating to the patient, including all admission forms and demographic information, medication, medical history, orders (physician/LRP), psychiatric evaluation, clinical testing information and other treatment information.)

❑ HIV or AIDS test results ❑ Mental Health records/test results /diagnosis

GENETIC TEST RESULTS—You must specify the test results to be released by checking or writing below:

Chromosome Analysis (specify below):

- ❑ Blood ❑ Bone Marrow ❑ CVS
- ❑ Amniotic Fluid ❑ Tissue
- ❑ Factor V Leiden
- ❑ Prothrombin DNA
- ❑ Urovysion
- ❑ Other_____
- ❑ Methylenetetrahydrofolate Reductace
- ❑ Her2/neu Fish for breast cancer
- ❑ Cystic Fibrosis

Marketing

If I am providing authorization for marketing purposes, I understand that

- ☑ Woman's Hospital will not receive a monetary benefit from a third party for the use of my patient information.
- ❑ Woman's Hospital will receive a monetary benefit (directly or indirectly) from a third party for the use of my patient information.

Authorization Expiration Date or Event

Unless otherwise revoked, this authorization will expire on the indicated date, event or condition. If an expiration date, event or condition is not specified below, this authorization will expire one (1) year from date of signature. For genetic information, the expiration date must be sixty days or less from date of signature. If no expiration date is specified, the authorization will expire sixty days from date of signature. The statement "end of research," "none," or similar language is sufficient if disclosure is for research, (*except for research on genetic information*) including the creation and maintenance of a research database or repository.

Expiration (Month, Day, Year / Event / Condition) _____

REQUIRED STATEMENTS

I understand that**:**

1. Authorizing the release of this health information is voluntary and I can refuse to sign this authorization.
2. I have the right to revoke this authorization at any time (*upon written notification to the Health Information Management Department at Woman's Hospital)* except to the extent that Woman's Hospital has already released the health information before receipt of the revocation. For genetic information, I have the right to revoke the authorization at any time before the disclosure is actually made or when I am made aware of the details of the genetic information.
3. If the authorization is for research, the researcher may continue to use and disclose the health information collected prior to the receipt of the written revocation.
4. Woman's Hospital cannot condition treatment, payment, enrollment, or eligibility for benefits on the patient providing this authorization.
5. If the authorization is for research-related treatment, Woman's Hospital may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research.
6. Any release of information carries with it the potential for an unauthorized redisclosure by the Recipient and the information may not be protected by federal law.
7. The authorization shall be invalid if used for any other purpose other than the described purpose for which the disclosure is made.
8. A photocopy of this authorization may serve as an original.

Patient's Signature X _____ Date _____

Personal Representative's Signature (if necessary) _____ Date _____

Personal Representative

If it is necessary for a personal representative to sign and date this authorization due to lack of capacity of the patient, including minority, interdiction or any other legal reason, indicate below how the person signing as representative has authority to do so:

- ❑ The ***court appointed person acting for the patient***, if one has been appointed.
- ❑ An agent acting pursuant to a valid mandate, specifically authorizing the agent to make health care decisions.
- ❑ The patient's spouse not judicially separated.
- ❑ An adult child of the patient.
- ❑ Any parent, whether adult or minor, for his minor child.
- ❑ The patient's sibling.
- ❑ The patient's other ascendants or descendants.
- ❑ Any person temporarily standing in ***for the parents***, whether formally serving or not, for a minor under his care and any guardian for his ward.
- ❑ Other (Please specify): _____

For Office Use Only:

Date copy of authorization given to patient _____

Date copy of authorization mailed to patient _____

Date records sent _____

Media of records disclosed (other than paper): ❑ CD ❑ Film ❑ Other_____