

Maury Regional Health*

Authorization to Release Protected Health Information

Patient Name: _____ Birth Date: _____ Last 4 digits of S.S. # _____

Address: _____ Phone # _____

I request and authorize: _____

To Release my health information to: _____
(Myself or the Name and Address of Recipient– Specify: Attorney, Insurance, etc.)

To Obtain my health information from: _____
(Name and Address – Specify: Hospital, Physician, etc.)

PURPOSE: Further Care Legal Insurance Payment or Billing Personal Use Social Security/Disability

Date(s) of treatment to be released: _____ to: _____ (enter specific date or dates)

Information to be released: Lab Reports Imaging (X-ray) Reports ER Records Billing Other _____

Medical Record Abstract (History & Physical, Discharge Summary, Consults, Operative Report, and Pathology, if applicable)

I would like: Paper copies Copies on a CD Copies on a USB flash drive an electronic file emailed** to me at:

Email address: _____

I understand that:

- I do not have to sign this authorization in order to receive treatment, payment or to be eligible for benefits.
- the release of my information may include information regarding diagnosis and/or treatment from other facilities or providers.
- this authorization will remain in effect for **ninety (90) days** after the date recorded below.
- this authorization can be taken back (revoked) at any time with a written request to the HIM Department (Medical Records).
- revoking this authorization stops further release but cannot undo any release of information that may have already occurred.
- once the information is released because of this request, it could be released by the recipient and the information may no longer be protected by federal privacy regulations.
- sending an unencrypted or unsecured email poses the risk of the file being viewed by unknown persons through the internet.
**The records will be emailed in a secure/encrypted manner unless instructed otherwise.

- I also understand that my records may include information regarding the diagnosis or treatment for alcohol and/or drug abuse; psychiatric or mental illness; and/or sexually transmitted diseases (STDs), as well as AIDS or HIV information **AND** that I can limit the release of this type of information.
- My signature below authorizes the facility specified above to furnish or obtain the information specified above even though the confidentiality of the information may be protected by Federal and State law and regulations.
- The facility is hereby released and discharged of any liability, and I will hold the facility harmless for complying with this authorization.

Printed Name of Patient or Authorized Individual _____ Signature of Patient or Authorized Individual _____ Date and Time of Signature _____
(If the above signature is not that of the patient, please explain why. Documentary evidence of guardianship may be required to accompany this form.)

Relationship to patient and/or description of authority to act for the patient _____

Photo ID was provided: Yes No - If No, specify form of patient identification: _____

Form 131 08/2018



131