Keralty Hospital

FOR OFFICIAL USE ONLY:

Admission #: _____

Received: _____

Completed:_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Patient (First, Middle, Last) _____ Date of Birth _____

Previous Name, if Applicable _____ Social Security #: _____

Daytime Telephone Number _____

INFORMATION MAY BE DISCLOSED BY:

Name/Organization: **KERALTY HOSPITAL**

Address **2500 SW 75 AVE**

Phone #: **305-264-5252 EXT 1705** Fax #: **305-675-0372**

INFORMATION MAY BE DISCLOSED TO:

Name/Organization: _____

Address: _____

Phone #: _____ Fax #: _____

INFORMATION TO BE DISCLOSED:

- ❒ Emergency Room Records
- ❒ History & Physical
- ❒ Admission note
- ❒ Consultations
- ❒ Discharge summary
- ❒ Radiology Films
- ❒ Radiology Reports
- ❒ Operative report
- ❒ Pathology Report
- ❒ Progress Notes
- ❒ Medications
- ❒ Laboratory Results
- ❒ Other: _____

PURPOSE OF DISCLOSURE OF MEDICAL RECORDS INFORMATION:

- ❒ Use by another health care provider
- ❒ Personal copy
- ❒ Attorney request
- ❒ Other: (*please describe*) _____

RESTRICTION ON DISCLOSURE FOR INFORMATION CONTAINED IN THE MEDICAL RECORD:

_____

EXPIRATION DATE: This authorization will expire in thirty (30) days from the date on which it was signed.

RE-DISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed or provided to others. This re-disclosed information may not be protected by federal privacy laws or regulations. Therefore, this facility is released from any and all legal liability that may arise from the re-disclosure of the requested information.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that the disclosing organization will not condition my treatment on completing this form.

SENSITIVE RECORDS: Unless specifically restricted by me, I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse. Federal regulations (42CFR, Part 2) prohibit making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

REVOKING THE AUTHORIZATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Date _____ Signature of Patient or Legal Representative _____ Relationship to Patient _____

Date _____ Witness _____