Sharon HOSPITAL
A RegionalCare Hospital Partners Facility

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Patient Name:_____

Previous Names:_____ **Date of Birth:**_____ **Telephone Number: (____)**_____

1. **I authorize Sharon Hospital to** **[ ] RELEASE Protected Health Information TO**

   [ ] OBTAIN Protected Health Information FROM

2. **The information identified above may be used by or disclosed to the following individual or organization:**

   Name:_____

   Address:_____

3. **The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated): Date of Service**_____

   [ ] History and Physical **[ ] Discharge Summary** **[ ] Cardiology Reports**

   [ ] Operative Report **[ ] Lab Results** **[ ] Physical/Speech/Occupational Therapy**

   [ ] Radiology Reports **[ ] Radiology CD/Films** **[ ] Emergency Room Record**

   [ ] Other (Please describe):_____

4. **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 and drug abuse.** _____**(patient/legal representative initials)**

5. **The information for which I'm authorizing disclosure will be used for the following purpose:**

   [ ] Personal **[ ] Insurance**

   [ ] Continuation of Care **[ ] Legal**

   [ ] Other (please describe):

6. **I understand that I have a 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 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.**

7. **If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed. This authorization will expire (insert date or event):**_____

8. **I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.**

9. **I understand authorizing the use or disclosure of the information identified is voluntary. I need not sign this form to ensure healthcare treatment.**

_____ _____

Signature of Patient or Legal Representative **Date**

If signed by legal representative, relation to patient: _____

_____ _____

Signature of Witness **Date**