



SCA.ROI

Authorization to Use and/or Disclose Protected Health Information

Request Completed by _____ (staff initial) Medical Record # _____

I hereby authorize _____ to use and/or disclose the Protected Health Information specified below from my medical records:
Hospital Name

1) PATIENT NAME: (Please Print) _____ Date of Birth: _____

Address: _____
Street City State Zip

Contact Telephone Number(s): _____

Email: (if applicable) _____

2) INFORMATION TO BE DISCLOSED TO:

Person or Facility Name (Please print) _____

Fax # _____

Address (Please print) _____
City State Zip

Phone # _____

Email: (if applicable) _____

3) Preferred Delivery Method -
Email
Postal Mail to address in # 2 above
In Person Pick-Up

4) Treatment Dates From: _____ To: _____

5) SPECIFIC RECORDS/REPORTS(S) TO BE RELEASED:

- Admission History and Physical Laboratory Results Rehab Services (PT, OT, Speech)
- Discharge Summary Imaging Reports (Specify CT, X-Ray, MRI) Other (be specific)
- Emergency Room Pathology Reports _____
- EKG Reports Operative Notes _____

6) RESTRICTED RELEASE: We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
<input type="checkbox"/> Mental/Behavioral Health Provider Documentation*		<input type="checkbox"/> Genetic Testing/Test Results*	
<input type="checkbox"/> HIV/AIDS Screening Test Results		<input type="checkbox"/> Alcohol*** <input type="checkbox"/> Treatment*** and/or <input type="checkbox"/> Substance Abuse	
<input type="checkbox"/> Confidential Communications with a Social Worker		<input type="checkbox"/> Child/Elder Abuse and Neglect	
<input type="checkbox"/> Rape/Sexual Assault Victim's Counseling		<input type="checkbox"/> Domestic Violence Victim's Counseling	
<input type="checkbox"/> Sexually Transmitted Disease			

* This authorization is not valid for use or disclosure of psychotherapy notes

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

***Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment." (42 CFR Part 2) Does not include records created or maintained by a general medical facility.

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

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Authorization to Use and Disclose
Protected Health Information – Release

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(Revised 02/12, 05/14, 08/14, 04/15, 09/16, 04/17, 08/21, 12/21)

Patient Label



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7) EXCLUSION REQUEST:

I request that the following admission(s) / visit(s) be specifically excluded from this request _____ (specify dates of service)

8) PURPOSE OF THE DISCLOSURE:

Medical Care Legal Insurance Personal Other _____

*fees may apply

9) TERM: This Authorization will remain in effect for one year or:

- Until _____ fulfills this request.
Hospital Name
- From the date of this Authorization until the _____ day of _____ 20_____
- Until the following event occurs: _____
- Other: _____

10) REVOCATION: I understand that I may revoke this Authorization at any time by requesting it of _____ in writing at the address listed below. The revocation will be effective immediately upon _____ receipt of my written notice. I understand that the revocation will not have any effect on any action taken by _____ reliance on this Authorization before it received my written notice of revocation.
Hospital Name

Attention Health Information Management

HOSPITAL NAME _____
Address _____

11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at _____.
Hospital Name

12) POTENTIAL FOR REDISCLOSURE: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by _____.
Hospital Name

13) ACCESS: I understand that in certain circumstances _____ has the right to deny me access to all or portions of my Protected Health Information _____ will notify me in writing of any such denials.
Hospital Name

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize _____ to use and/or disclose my health information in the manner described above.
Hospital Name

14) _____
Signature of Patient _____ Date _____

Printed Name of Patient _____ Witness _____

For Office Use:
 I.D Verification _____

Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

15) _____
Signature of Personal Representative _____ Date _____

Printed name of Patient Representative _____ **15)** _____
Relationship to patient or authority to act for patient

Questions about the release should be directed to the hospital HIM Director.

For Office Use:

- Copy of this authorization provided to the patient
- Copy of this authorization provided to the personal representative

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