Your Hospital's Logo Here

AUTHORIZATION TO DISCLOSE
Protected Health Information (PHI)

I, _____,

authorize to disclose to YOUR HOSPITAL*, Nursing Unit, Phone # & Fax #:

_____ _____ _____
Nursing Unit | Telephone # | Fax #

PHI at the time of disclosure and at anytime in the future on _____
Patient's Name

_____ _____ _____
Date of Birth | Social Security Number | Telephone #

for the specific purpose of: _____

Protected health information to be disclosed includes: _____

_____

This authorization expires in 60 days from date of signature, or sooner by date _____,

or by future event as specified, _____

☐ **I DO**

☐ **I DO NOT**

authorize release of information related to psychological or psychiatric impairment, substance abuse, alcoholism, Acquired Immunodeficiency Syndrome (AIDS), test for Human Immunodeficiency Virus (HIV), sexually transmitted diseases, sexual assault and criminal cases and photographs.

THE FOLLOWING NOTICE MUST BE READ BEFORE THIS AUTHORIZATION IS SIGNED BY THE PATIENT OR PERSONAL REPRESENTATIVE.

A patient has a right to revoke this authorization only by writing to the Health Information Department at Your Hospital, and revocation becomes effective on the date received. You are notified that once the requested PHI is disclosed, the PHI's recipient may redisclose it and the Privacy Regulations may no longer protect it. Treatment, payment, enrollment or eligibility for benefits are not conditioned on Xxxxx Hospital securing signature on this authorization.

_____ _____
DATE | SIGNATURE of PATIENT or PERSONAL REPRESENTATIVE WITH AUTHORITY

* YOUR HOSPITAL includes (affiliated hospitals here).

PART OF THE MEDICAL RECORD