HARDIN MEMORIAL HOSPITAL
A Regional HealthCare Center

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Medical Record Number: _____

Visit Number: _____

(For Department Use Only)

COMPLETE ALL INFORMATION ON FORM ☐ Mail ☐ Pick Up

Patient's Full Legal Name: _____

Date of Birth: _____ SS #: _____ Telephone Number: _____

Address: _____

I hereby authorize **NAME OF FACILITY** or _____
to use or disclose my health information, as described below. I further authorize the following individuals or organizations to receive my health information:
(**NAME OF INDIVIDUAL/FACILITY):** _____

The purpose of the requested use or disclosure is:
☐ At the request of the individual or ☐ Other (please specify): _____

_____

The information to be used or disclosed includes the following specified information:

☐ Discharge Summary	☐ Consultation	☐ ER Notes	☐ Psychiatric Evaluation
☐ History & Physical	☐ Laboratory Reports	☐ Diagnostic Report	☐ Psychosocial Assessment
☐ Operative Report	☐ Pathology Reports	☐ All of the above	
☐ Radiology Reports	☐ Radiology Films	☐ Other (Must be Specified): _____	

TIMEFRAME: I would like all records from the following dates: _____ through _____.

I understand that the information in my health record may include information related 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/or drug abuse.

Federal law protects the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected.

The provision of treatment may not be conditioned upon the execution of this authorization unless treatment is provided in conjunction with research or if the purpose of the treatment is solely for disclosing information to a third party (i.e. fitness for work or life insurance examination).

This authorization will expire upon the occurrence of the following date or condition: _____. If no date or condition is listed, it will expire in **90 days**. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to Health Information Management Services at Hardin Memorial Hospital. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand that I will be given a copy of this Authorization form, after signing it.

It is understood that my record may not be released to me at the time requested, and that if I am requesting a copy of my healthcare information at the point of care, that it may be "incomplete" until all healthcare providers have had a chance to complete their documentation in the record. Normal processing time is 3 to 5 days, however it could take up to 30 days from the time I have requested my records. In a case where my physician needs my medical record for an appointment, the HIMS department will send my record after I provide them with my physician's name and phone number.

_____ _____

Signature of Patient/Authorized Representative **Date**
(Include relationship or nature of authority)

_____ _____

Signature of Witness if not signed in presence of Hardin Memorial Hospital Staff **Date**

_____ _____

Signature of Hardin Memorial Hospital Staff verifying identification **Date**