AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize **SUMMIT HEALTHCARE** to disclose **protected health information ("PHI")** from the health records of:

Patient Name: _____ Phone Number:_____

Address: _____

Medical Record # OR Date of Birth: _____

Authorize "PHI" from (date)_____ to (date)_____

Disclose to: (Name)_____

(Address)_____

(Phone)_____ (Fax)_____

Specific description of the information to be disclosed:	**Specific description of the purposes of the disclosure:**	**I authorize the provider to use or disclose information related to (check all that apply):**
☐ Discharge Summary ☐ History and Physical Exam ☐ Operative Reports ☐ X-ray Reports ☐ Lab Tests ☐ Other (specify) _____ _____ _____	☐ Continued Patient Care ☐ Workers' Compensation ☐ Insurance Coverage or Payment for Care ☐ Other (specify) _____ _____ _____ **- OR -** ☐ The disclosure is at my (the patient's) request	☐ AIDS/HIV and other Communicable Disease ☐ Behavioral Health Care/ Psychiatric Care/ Mental Health Information ☐ Alcohol and/or Drug Abuse Treatment ☐ Genetic Testing Information

I understand that the Hospital will not condition treatment on my signing this authorization. The Hospital will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form.

I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the Hospital's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the Medical Records Department. Unless I revoke this authorization earlier, it will expire on the following date:_____**.** If date is left blank, it is understood that the expiration date will be one year from patient signature date.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by The federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and Directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Patient Signature (please send photocopy of picture I.D.) Date

_____ _____

Signature of Legal Representative (please send photocopy of legal document AND photocopy of picture I.D.) Relationship to Patient OR Description of Authority to Act for Patient

If other than patient, form filled out by:

_____

(print name)

Translation by:_____

(print name).

☐ Faxed to _____

☐ Mailed to _____

☐ PHI given to patient

Summit Healthcare

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