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

Patient Name:_____ Phone number: _____

Address: _____

Date of Birth OR Medical Record #: _____

Authorize "PHI" Date of Service from (date) _____ to (date) _____

Disclose to: (Name): _____ ☐ See attached addendum

(Address) _____

(Phone)_____ (Fax) _____

COMPLETE ALL 3 BOXES		COMPLETE ALL 3 BOXES
Specific description of the information to be disclosed: ☐ Discharge Summary ☐ History and Physician Exam ☐ Operative Reports ☐ X-ray Reports ☐ Lab Tests ☐ Progress Notes ☐ Consultations ☐ Other (specify) _____ _____ _____	**Disclosure of ***Protected information - Only Summit generated records will be released. The following protected information may be released:** **Yes** **No** ☐ ☐ AIDS/HIV and other Communicable Disease ☐ ☐ Behavioral Health Care/ Psychiatric Care/Mental Health Information ☐ ☐ Substance Use and/or Treatment ☐ ☐ Genetic Testing Information	**Specific description of the purpose(s) for disclosure:** ☐ Continued Patient Care ☐ Workers' Compensation ☐ Insurance Coverage or Payment for Care ☐ Other (specify) _____ _____ _____ - OR - ☐ The disclosure is at my (the requestor's) request

I understand that Summit Healthcare will not condition treatment on my signing this authorization. Summit Healthcare 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 Summit Healthcare'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 federal privacy regulations and may be **re-disclosed** by the person or organization that receives the information **(Exception: ***Protected Information listed above may NOT be re-disclosed.)**

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 Date

(please provide photocopy of picture I.D.)

_____ _____

Signature of Legal Representative Relationship to Patient OR

(please provide photocopy of legal document and your picture ID) Description of Authority to Act for Patient

NOTE: Federal law/42 CFR Part 2 prohibits unauthorized disclosure of these records

RECORDS RELEASED BY

_____

(print name)

Translation by: _____

(print name)

_____

☐ Faxed to _____

☐ Mailed to _____

☐ PHI given to requester

_____

Employee Signature Date/Time