

NEWMAN REGIONAL HEALTH

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Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations. If any section is incomplete, this form may be invalid.			
Patient Name: _____		Birth Date: _____	
Social Security No. (optional): _____			
Patient Phone #: _____			
I authorize information to be released: <input type="checkbox"/> From <input type="checkbox"/> To		I authorize information to be released: <input type="checkbox"/> From <input type="checkbox"/> To	
<input type="checkbox"/> Newman Regional Health (Hospital Records) <input type="checkbox"/> Newman Regional Health Express Care <input type="checkbox"/> Newman Regional Health Occupational Health <input type="checkbox"/> Newman Regional Health Cardiology Clinic <input type="checkbox"/> Newman Regional Health ENT Clinic <input type="checkbox"/> Newman Regional Health Family Medicine Clinic <input type="checkbox"/> Newman Regional Health Orthopedics & Sports Medicine Clinic <input type="checkbox"/> Newman Regional Health Pediatric clinic <input type="checkbox"/> Newman Regional Health Psychiatry Clinic <input type="checkbox"/> Newman Regional Health Surgical Specialists Clinic		Recipient's Name: _____ Address: _____ City/State/Zip: _____ Phone #: _____ Fax# _____ E-mail ID: _____ <input type="checkbox"/> Newman Regional Health Hand in Hand Hospice <input type="checkbox"/> Newman Regional Health Medical Equipment & Supply	
REQUEST DELIVERY:			
<input type="checkbox"/> Fax <input type="checkbox"/> Encrypted e-mail <input type="checkbox"/> Pick up <input type="checkbox"/> US Mail		Media: <input type="checkbox"/> Paper Copy <input type="checkbox"/> USB Drive	
PURPOSE OF DISCLOSURE:			
<input type="checkbox"/> Treatment/Continued care <input type="checkbox"/> Relocating <input type="checkbox"/> Insurance Purposes <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Personal Reasons <input type="checkbox"/> Other:			
Description of information to be used or disclosed:			
Dates of Service From: _____ Through: _____			
HOSPITAL RECORDS		CLINIC RECORDS	
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Anesthesia Record <input type="checkbox"/> Social Work Records <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Diagnostic Test Reports <input type="checkbox"/> ER Records <input type="checkbox"/> History & Physical		<input type="checkbox"/> Discharge Records <input type="checkbox"/> Laboratory Records <input type="checkbox"/> Lab Specimen/Slide <input type="checkbox"/> Nursing Notes/Records <input type="checkbox"/> Operative Reports <input type="checkbox"/> Pharmacy Records <input type="checkbox"/> PT/ST/OT Records	
<input type="checkbox"/> Phys Progress Notes <input type="checkbox"/> Physician Orders <input type="checkbox"/> Respiratory Therapy Notes <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Itemized Bill: <input type="checkbox"/> UB-04: <input type="checkbox"/> Other:		<input type="checkbox"/> All PHI in medical record (past 3 yrs only) <input type="checkbox"/> Immunizations only <input type="checkbox"/> Billing Records only <input type="checkbox"/> Radiology Images on CD <input type="checkbox"/> Only Information related to: <input type="checkbox"/> Other:	
<i>I understand that requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrom (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse (CFR 42).</i>			
I understand that I may refuse to sign this authorization and understand that it is strictly voluntary; however NRH cannot honor my request to release information or records without a signed authorization. See 45 CFR 164.514 (b)(1). My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. Records within the scope of this authorization (check marked above) may be disclosed pursuant to this authorization. Subsequent records will not be automatically released. If subsequent records within the scope of this authorization are requested, the patient or recipient is responsible for notifying NRH of such request. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it, if requested.			
Section B: The request of PHI is for the purpose of marketing			
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____			
Section C: Signatures			
I have read the above and authorize the disclosure of the protected health information as stated.			
_____ Signature of Patient/Patient Representative If you prefer this authorization to expire before 6 months from today – list expire date here: _____		_____ Date (Auth. expires 6 months from this date)	
_____ Print Name of Patient's Representative		_____ Relationship to Patient	
Internal Use: M#: _____		F#/A#: _____	
Witness Signature:	Date Printed:	Date Logged:	Date Released:
Specific Records Released:	Type of ID:	Printed by:	# Pages: