



**AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize Silver Cross Hospital to receive &/or disclose information from the health records of:

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_

Medical Record Number \_\_\_\_\_ Hospital Visit Number \_\_\_\_\_

The specific information to be used or disclosed is as follows:

- \_\_\_\_\_ complete health record (every page)
- \_\_\_\_\_ abstract of record: (includes the following reports)
  - \_\_\_\_\_ discharge summary \_\_\_\_\_ history & physical \_\_\_\_\_ emergency room record \_\_\_\_\_ consultations
  - \_\_\_\_\_ operative reports \_\_\_\_\_ pathology reports \_\_\_\_\_ laboratory reports \_\_\_\_\_ radiology reports
  - \_\_\_\_\_ cardiology reports \_\_\_\_\_ other testing results \_\_\_\_\_ OT/PT summary \_\_\_\_\_ immunization record
- \_\_\_\_\_ physician orders
- \_\_\_\_\_ physician progress notes
- \_\_\_\_\_ nurses notes
- \_\_\_\_\_ medication record
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

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), if any. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**This information may be disclosed to and used by the following individual or organization:**

\_\_\_\_\_

**Address:** \_\_\_\_\_

**for the purpose of** \_\_\_\_\_  
*(e.g. further care, insurance claim, attorney inquiry, at the request of the individual, personal use, etc)*

I understand that I have a right to revoke this authorization, in writing to the HIM/Medical Record Department, at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

**This authorization is valid until:**

*(If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days)*

I understand that this authorization is voluntary. I can refuse to sign this authorization. I understand that if I refuse to sign this authorization, the hospital may not refuse to treat me or refuse to submit claims for services to my health plan. I understand that I have a right to inspect and copy the information to be used or disclosed pursuant to this authorization. I understand that once this information is received by the authorized person or organization, then it may be subject to redisclosure and may no longer be protected by federal privacy laws.

**I hereby authorize the above use and disclosure:**

\_\_\_\_\_  
*Signature of Patient or Legally Authorized Representative* \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed name of legal representative* \_\_\_\_\_  
*Representative's relationship to Patient* \_\_\_\_\_  
*# of pages released*

\_\_\_\_\_  
*Signature of Witness* \_\_\_\_\_  
*Date* \_\_\_\_\_  
*Released by* \_\_\_\_\_ *04/03*