

SILVER CROSS HOSPITAL
AUTHORIZATION FOR USE & DISCLOSURE
OF HEALTH INFORMATION

PATIENT LABEL

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

Receipt Number _____

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). 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	Time
Printed name of legal representative	Representative's relationship to Patient	# of pages released
Signature of Witness	Date	Time
		Released by

