SILVER CROSS HOSPITAL

PATIENT LABEL

Authorization for Release of Info Disclosure

I hereby authorize Silver Cross Hospital to receive and/or disclose

_____

_____

<u>DELIVERY METHOD</u> FOR DUPLICATION OF RECORDS:

- ☐ MAIL PAPER DUPLICATION
- ☐ MAIL CD/DVD DIGITAL DUPLICATION
- ☐ FAX DUPLICATION
- ☐ PICK UP PAPER DUPLICATION
- ☐ EMAIL/ELECTRONIC DIGITAL DUPLICATION

DIGITAL DUPLICATION WILL BE PROVIDED IN PDF FORMAT. YOU CAN OBTAIN A COPY OF ADOBE READER AT http://www.adobe.com/

MAIL/ELECTRONIC DELIVERY NOTICE:

I understand Emails can be intercepted, altered, forwarded, or used without authorization or detected. Emails can be circulated, forwarded and stored in both electronic and paper formats. Email addresses can be incorrectly written or typed. Emails can be inadvertently exposed, lost during creation and transmission due to technical failure. I understand and accept the risk using an unsecure email. I agree for ScanSTAT Technologies to email me my protected health information on behalf of Silver Cross Hospital when the email delivery method is chosen and I fully understand the risk involved in using the email delivery method.

PLEASE SIGN IF YOU AGREE AND ACKNOWLEDGE _____

PLEASE PROVIDE AN EMAIL FOR ELECTRONIC DELIVERY

PLEASE PROVIDE A PREFERRED PASSWORD MUST CONTAIN 8 TO 12 CHARACTERS

CNT97

51200