Hamilton Community Health Network

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Authorization For Release of Protected Health Information

Date **Full Name** **DOB** **Social Security Number**

Name and address of person(s) or Organization(s) by whom disclosure Is to be made
RELEASED FROM:_____

_____

_____

Phone:_____Fax:_____

Name and address of person(s) or Organization(s) by whom information is to be given
RELEASED TO: _____

_____

_____

Phone:_____ Fax:_____

Specific Information to be Disclosed (Include type and dates of service):

_____

_____

Purpose and Need of Disclosure:_____

_____

My authorization is given freely with the understanding that: I may refuse to sign this authorization; I may revoke this authorization at any time except where information has already been released in reliance on my authorization, provided that any such revocation is in writing. HCHN may not condition my treatment on my provision of this authorization; this authorization is valid for a 60 day period from the date it is signed or sooner if specified by me, as indicated below; a photocopy or fax of this authorization is as valid as the original; HCHN, its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein; I will be given a copy of this signed authorization if the authorization is at the request of HCHN;

I understand that my/my son's/daughter's records (including alcohol, drug abuse, mental status, and serious infectious and communicable diseases including venereal diseases, tuberculosis, HIV, AIDS and ARC) are protected under the State of Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may revoke this authorization at any time and that this authorization pertains to fulfillment of the above states purpose(s).
I have read the above and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I DO HERBY CONSENT TO DISCLOSURE OF THE ABOVE DESCRIBED INFORMATION CONTAINED IN MY/MY SON'S/ DAUGHTER'S HEALTH RECORD.

_____

Date Patient's or Parent's/Guardian's Name (Print) and Signature

_____

Date Witnessed By:

Prohibition of re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. Federal Regulations (42 CRF Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is held by another party is not sufficient for this purpose. Drug abuse office and treatment act of 1972 (21 USC 1175) comprehensive alcohol abuse, alcoholism prevention, treatment and Rehabilitative Act of 1970 (42USC 4582), federal register, Vol. 40.127, July 1, 1975.

Requested by:_____
Physician Name (Please print)