Authorization for Use and Disclosure of Protected Health Information

☐ Effingham Health System (EHS) ☐ Effingham Care and Rehabilitation Center

☐ EHS Practice _____ ☐ Other _____

This authorization outlines disclosure of my individually protected health information (PHI) for purposes other than those that are outlined in the Privacy Rule for treatment, payment, and health care operations. By signing, I am agreeing to disclosure of my PHI voluntarily. I further understand that once disclosed, this information may be re-disclosed by the recipient and no longer protected under the Privacy Rule.

Patient Name _____ Medical Record Number _____ Account Number _____

Date of Birth _____ *Last four digits of* Social Security Number _____

This disclosure is being made at the request of: *(Please indicate relationship to patient)*:

Self ☐ Other ☐ (Please print name) _____

Please print name/address/fax number to release PHI to: _____

_____

_____

I, authorize the above-named facility/office to disclose and release the specified PHI as indicated below:

Release in the following format: ☐ **Electronic Request (CD only)** ☐ **Paper Request**

Please list reason: _____

I authorize release of the following specified PHI for the period of (list dates):

_____ TO _____

☐ Copies of **ALL** Records	☐ Billing Records	☐ Lab Specimen
☐ Copy of History and Physical	☐ Copy of Radiology Reports	☐ Blood Specimen
☐ Copy of Lab Reports	☐ Radiology Films (CD only)	☐ Pathology Tissue

Please initial _____ I place **NO limitations** on history of illness or diagnostic and therapeutic information, including any treatment for:

1. Alcohol, drug abuse, or dependency;
2. Psychiatric or psychological, mental illness or retardation; or
3. Acquired immune deficiency syndrome (AIDS).

Authorization for Use and Disclosure of Protected Health Information

The facility may not condition treatment, payment, enrollment or eligibility as consequences for not signing this authorization except for those reasons as are outlined in the Privacy rule, i.e., claims, billing and insurance of and for the individual. The release in any manner of all information is authorized by my signature and I do hereby release all persons, agencies, firms, companies, etc., from any damages resulting from providing such information.

I understand that I may receive a copy of this authorization and an additional copy will be maintained by the facility.

This authorization is valid for one (1) year from the date of my signature below, unless otherwise noted. I understand that I may revoke this request at any time by submitting a request for revocation in writing to the facility Privacy Officer or Designee. I further agree that I may not hold the facility or recipient liable for any use or disclosure that may have occurred prior to receipt of my revocation.

Document type of Photo ID checked: _____

Signature	Date/Time
Printed Name	Relationship
Signature of Witness	Date/Time
Title/relationship of witness	

For Original Film/Specimen Return Only:

Signature of receiving personnel	Date/Time received