

HUNTINGTON MEDICAL FOUNDATION

DISCLOSURE AUTHORIZATION

SECTION A: Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name: _____

Date of Birth: ____/____/____

Person(s)/organizations authorized to use/disclose Information (from):

Person(s)/organizations authorized to receive the Information (from):

Information that may be used/disclosed:

(Including dates where appropriate, e.g., medications dispensed in December 2002 or EKG Report performed in June 2000)

- Records of Visits (all) _____
- Records of Visit(s) (Specific) _____
- Discharge Summary _____
- History/Physical _____
- Consultation Report(s) _____
- Operative Report(s) _____
- Problem List _____
- Progress Notes _____
- Immunization Record(s) _____
- Medication Record(s) _____
- Laboratory Report(s) _____
- X-Ray, MRI, CT _____
- Echo, Stress Test, Holters _____
- EKG Reports _____
- Mental Health/Alcohol/Drug Abuse Treatment _____
- AIDS or HIV Information _____
- Hepatitis Information _____
- Entire Medical Record _____
- Statement of Changes/Payments _____
- Other _____

SECTION B: Must be completed only if health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

a. The information will be used/disclosed for the following purpose:

- Continued Patient Care
- Disability Determination
- Personal Use
- Attorney/Legal
- Insurance Claim
- Other _____

- b. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes No
2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.
3. I understand that I may inspect and copy any information to be used or disclosed.

SECTION C: Must be completed for all authorizations

1. I understand that I may revoke this authorization at any time by notifying Health Information Management Department in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires

(INSERT APPLICABLE DATE OR EVENT THAT TRIGGERS EXPIRATION)

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

SIGNATURE OF PATIENT OR REPRESENTATIVE

_____/_____/_____
TODAY'S DATE

PRINTED NAME OF PATIENT'S REPRESENTATIVE (IF APPLICABLE)

RELATIONSHIP TO PATIENT