REQUEST AND AUTHORIZATION TO USE OUTSIDE HEALTH INFORMATION

PLEASE COMPLETE THE FOLLOWING FORM IN FULL

I, _____
Name: First Middle Last Date of Birth (mm/dd/yyyy)

Hereby authorize: _____
Provider's Name

Address: _____

Telephone #: _____ Fax #:_____

To disclose the following Health Information about me (*check each box that applies*):

- ☐ **My entire medical record**
- ☐ **Office visit notes**
- ☐ **Diagnostic test results**
- ☐ **Radiology Studies (MRI, X-ray, etc)**
- ☐ **Hospital abstract**
- ☐ **Operative report**
- ☐ **Other - Specify Information Required: _____**

_____

_____

RELATING TO THE TIME PERIOD _____through_____

My health records may contain the following information listed below, and if checked, I specifically authorize the information's release:

- ☐ **Mental Health Diagnosis & Treatment**
- ☐ **HIV/AIDS Testing, Diagnoses, & Treatment**
- ☐ **Sexually Transmitted Disease Testing, Diagnoses, & Treatment**
- ☐ **Drug or Alcohol Addiction Diagnoses or Treatment**
- ☐ **Genetic Testing Results**

To the following Specialty or Provider at Summit Health located at.:

_____
Name of Provider/Specialty

_____
Street Address **Building/Floor/Suite**

_____
City **State** **Zip Code**

Telephone #_____ Fax#_____

TERM: This authorization will expire upon the Provider's release of my Health Information as needed to fully accomplish the purpose(s) listed below or six (6) months from the date signed.

PURPOSE OF DISCLOSURE:

☐ Treatment

☐ Other (please specify) _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used and disclosed, as provided in 45 CFR 164.524.

I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA. I further understand that any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal and/or state confidentiality rules.

I understand that I have the right to revoke this Authorization, at any time before the provider's reliance thereon, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in Provider's Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority:_____

(please explain and attach required documentation)