1275 N. High Street
Hillsboro, Ohio 45133

AUTHORIZATION TO PERMIT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, ____, date of birth ______________________________
(Patient or Patient Representative) (Patient)

hereby authorize________________Highland District Hospital __________________to release my medical information to:

____.
(Specific identification of person or entity authorized to receive information)

I authorize the following information to be released: Date(s) of treatment:____

_____ History & Physical Exam _____ Discharge Summary _____ Lab report(s) _____ Radiology report(s)

_____ Progress Notes _____ Consultation(s) _____ Pathology report(s) _____ EKGs

_____ Operative Report(s) _____ Endoscopy report(s) _____ ER Record _____ CT/MRI report(s)

_____ Clinic report(s) _____ Physical Therapy _____ ER Dictation _____ Cardiopulmonary report(s)

_____ Entire Medical Record _____ Orders

_____ Other components (specify) ____

This authorization includes release of records relating to:

_____ HIV test results _____ AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment

This authorization for use/disclosure of the information described above is for the following purpose:

____

If the authorization is to permit the use or disclosure of the patient's information for marketing, indicate whether Highland District Hospital will receive any remuneration or payment from a third party as a result of the marketing:____

If you are the representative of a patient, describe the scope of your authority to act on the patient's behalf:

____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.

As described in the Notice of Privacy Practices of Highland District Hospital I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Highland District Hospital in reliance on this authorization, by sending a written revocation to the Privacy Officer, Highland District Hospital, 1275 North High Street, Hillsboro, Ohio 45133.

This authorization will expire: (Specify applicable date or specific event)____

I understand that I am not required to sign this authorization form and that Highland District Hospital will not condition the provision of treatment or payment to me on the signing of this authorization, except that Highland District Hospital may condition the provision of research-related treatment to me on the signing of this authorization for the use or disclosure of my PHI for such research. Highland District Hospital may also condition the provision of health care to me that is solely for the purpose of creating PHI for disclosure to a third party on the signing of this authorization.

____ ____
Patient Name – (Print) Signature of patient (or patient's representative)/Date

____ ____
Name of personal representative, if applicable – (Print) Relationship of personal representative to patient

____
Signature of Highland District Hospital representative/Date

**Make copy for patient/patient representative

C HW 1576 (7/13)