Haywood Regional Medical Center

For Office Use Only:
HIM Verified Time: _____ **By:**_____
D.Lic #: _____
Imaging Verified Time: _____ **By:** _____

AUTHORIZATION / REQUISTION (circle one)
FOR RELEASE OF INFORMATION

SECTION A: (This section to be completed by the patient)

Patient Name: _____ Medical Record#_____ Visit ID: _____

Patient Address: _____ Date of birth: _____

City, State, Zip Code: _____ Telephone#: _____

Encounter Date(s) to be released: _____

List the specific information that is authorized for disclosure: _____

❑ Anesthesia	❑ Consultation	❑ Discharge Sum	❑ EKG s	❑ Emergency	❑ Facesheet
❑ History/Phys	❑ Imaging Rpts	❑ Laboratory	❑ Medication	❑ Nursing	❑ Surgery/Proc
❑ Orders	❑ Imaging CD	❑ Pathology	❑ Progress Nts	❑ Billing Rec	❑ UB04
❑ Itemized Bill	❑ Outpatient	❑ Acct of Discl	❑ Entire Record	❑ Other	❑ _____

Name of Recipient: Enter the name/address/city/state/zip code and phone number of which the information **can be released to:** _____

_____

_____

Describe the purpose / reason for this request

_____

SECTION B: (Patient must read and complete information in this section

I hereby authorize ***Haywood Regional Medical Center*** to use/disclose my individually identifiable health information in the manner described within this authorization.

NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS OR MENTAL HEALTH WILL BE DISCLOSED UNLESS YOU SIGN HERE:

PATIENT/REPRESENTATIVE SIGNATURE_____**DATE**_____

- I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization or that refusal to sign this authorization will not affect my treatment.
- I understand that information used or disclosed to an entity other than a health plan or health care provider may be subject to re−disclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 CFR160 and 164.
- I understand that this authorization will expire on ____/____/____. (If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)
- I understand that I may revoke this authorization at any time by notifying ***Haywood Regional Medical Center*** in writing, except to the extent that has already taken in reliance of the previous authorization period.
- I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
- I understand that I have the right to see this information described on this form if I ask to see it and I understand that I may request a copy of this form after I sign it.
- **THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING − note that signature is required in two places.**

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre−pay for the copies; if not, then your copies will be mailed along with an invoice.
_____ **initial**

_____ _____

Signature of Patient Resident or Legal Representative Date

If not signed by patient, please indicate relationship: ❑ Parent or guardian of minor patient ❑ Guardian or conservator of incompetent patient ❑ Beneficiary or representative of deceased patient