HILLSDALE HOSPITAL

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS

*(patient MRN)*_____ *(date request made)*_____ *(account #)*_____

I: _____
full name of patient ***date of birth***

I authorize: ☐ Hillsdale Hospital to use/disclose my health information (as outlined below)
☐ Other: _____ to use/disclose my health information (as outlined below)

TO: ☐ Receiving Party: _____ ☐ Hillsdale Hospital
_____
_____

Specific type of information to be disclosed *(include dates of treatment, check all that apply)*
I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service or mental health records, communications made to a social worker and HIV/AIDs and AIDS related complex information or documentation, if such information exists.

☐ History/Physical ☐ Discharge Summary ☐ Operative/Path report ☐ Psychotherapy notes
☐ Mental health ☐ HIV/HIDS, and AIDs ☐ Drug and/or alcohol treatment
☐ Emergency Department record_____ ☐ Diagnostic testing (lab, x-ray, cardio) _____
☐ Other: _____ ☐ Reports only ☐ USB ☐ CD ☐ DVD

Purpose and need for disclosure
☐ Continuing care ☐ Insurance billing ☐ Disability ☐ Marketing
☐ Personal Use ☐ Fundraising activities ☐ Application for employment
☐ Enrollment in a Health Plan ☐ Other: _____

I understand that I may revoke this authorization at any time by sending a written revocation to Hillsdale Hospital except to the extent that Hillsdale Hospital has taken action in reliance on the authorization.

I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the receiving party and may no longer be protected by federal or state law.

I understand that my continued or future treatment by Hillsdale Hospital is not conditional upon my providing or signing this authorization unless this authorization is providing data in connection with medical or clinical trial research.

I understand that if Hillsdale Hospital is the receiving party, I have the right to inspect or copy the health information Hillsdale Hospital intends to use or disclose, pursuant to this authorization and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.

I further understand that correspondence, and records from other health care providers will not be released with this routine request.

Please be aware that there may be processing fees charged for multiple requests of the same information. There is no charge to send directly to another physician.

This authorization is made in accordance with federal and state law and is valid for a period of one year after being executed; however, it may be revoked by me at any time by providing written notice to the above named party. A facsimile or photocopy of this document will be accepted in lieu of the original.

_____ _____
Patient Signature or Legal Guardian ***Date*** *ID Number*

_____ _____
Witnessed by *Date*