

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, if any field is left blank, the authorization will be considered defective.

PATIENT'S NAME:	DATE OF BIRTH:	SSN:
ADDRESS:	MRN:	TEL. #

I authorize the use and disclosure of health information about me as described below:**

Facility Authorized to Release my Health Information:

HENDRY REGIONAL MEDICAL CENTER

Agency or individual(s) Authorized to Receive my Health Information:

Health Information that may be used/disclosed is limited to the following:

- Discharge Summary Consultation(s) Pathology Report Lab
 History & Physical Operative Note(s) Imaging/X-ray Entire Record
 Other (specify):

Health Information that may be used/disclosed is limited to the following Treatment Dates:

Health Information to be released to the above named agency / individual is to be used / disclosed for the following purposes(s) (include Research or Marketing, if appropriate):

Health Information identifies you (the patient) by name and includes other demographic information about you. Health Information may include, but is not limited to: medical records, x-ray films, slides, tracing strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status and/or psychiatric diagnoses complied during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies in this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health Information is use or disclosed for continues research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at anytime, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature:	Date:	Time:	<input type="checkbox"/> am
			<input type="checkbox"/> pm

Relationship to Patient/Authority to Act on Patient's Behalf (Interpreter, if utilized)	
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** There may be a charge for copying Medical Records

**Authorization to Use and Disclose Protected Health Information
HENDRY REGIONAL MEDICAL CENTER**