Authorization for Disclosure of Protected Health Information
(Request for Release of Records)

Patient's Name: _____ **Date of Birth:** _____

I do herby authorize

Northern Regional Hospital to disclose my health information to:

Name: _____

Address: _____

Phone: _____ Fax: _____

Please release the following information: _____

The purpose of the release is:

- ☐ Continuity of care
- ☐ Insurance
- ☐ Legal
- ☐ School/Work release
- ☐ Other: _____ (Please specify)

I authorize the use or disclosure of my protected health information as described above.

I have a right to receive a copy of this authorization. I am signing this authorization voluntarily. I understand that I may revoke this authorization at any time by presenting a request for revocation in writing to the Health Information Management Department of Northern Regional Hospital. I understand a revocation will not reverse any action taken in reliance upon this authorization. This authorization will expire in six months after the date of signing. I understand that the information disclosed pursuant to this authorization may include information concerning mental health, use or treatment concerning drugs and/or alcohol abuse under 42 CFR Part 2, HIV/AIDS, and/or other communicable disease, and genetic testing results.

I understand that the information disclosure pursuant to this authorization may be re−disclosed by the person(s) receiving this information and the information disclosed may no longer be subject to protection by federal privacy regulations or other laws.

Signed by Patient: _____ Date: _____

Signed by Personal Representative: _____ Date: _____

Witness: _____ Date: _____