UNDER HIPAA REGULATIONS, THIS RELEASE IS ONLY VALID IF ALL BLANKS ARE FILLED IN.

Patient's Name: _____ Birthdate: _____

Address: _____

Phone #: _____ I hereby authorized _____
(Write name of hospital, doctor office, etc.)

To disclose to: _____
(Write who is to receive the information)

Address: _____ Phone: _____

FROM this service date: _____ TO this service date: _____

I need the following reports, healthcare information etc.
(Write report types needed on the lines provided i.e. H&P, x-ray, lab, etc.): _____

_____

_____

The requested information will be used for (check one or more boxes below):

☐ Follow-up care ☐ Attorney ☐ Insurance ☐ Own Records

☐ Other: _____

I understand that my medical records (INCLUDING ANY ALCOHOL OR DRUG ABUSE AND MENTAL STATUS INFORMATION) may be protected by federal and state regulations. By signing this authorization, I'm allowing the release of ANY MEDICAL INFORMATION (DRUG AND ALCOHOL ABUSE OR MENTAL STATUS INFORMATION INCLUDED) requested to the agency specific above.

I understand I may revoke this consent at any time, unless the information has already been disclosed pursuant to a valid authorization and before I have withdrawn my authorization. (e.g. probation, parole, etc.) This authorization expires automatically as described below:

DATE, EVENT OR CONDITION UPON WHICH THIS EXPIRES: _____
(Day Month Year)

_____ _____ _____
Patient/Parent signature, court ordered guardian/representative **Relationship to patient** **Date**

_____ _____
Witness (hospital staff receiving this request) **Date**

I UNDERSTAND THIS AUTHORIZATION IS VOLUNTARY AND IF THE PERSON OR ORGANIZATION LISTED ABOVE IS NOT A HEALTHCARE PLAN OR PROVIDER, FEDERAL PRIVACY LAWS MAY NO LONGER PROTECT THE RELEASED INFORMATION.

Via Christi Hospital Pittsburg, Inc.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
VCP7020003 04/10

PATIENT IDENTIFICATION