Patient's Name: _____ Date of Birth: _____

MR#/Acct #: _____ Area Code & Telephone Number: _____
Social Security Number: _____

I hereby authorize the use/disclosure of Protected Health Information (PHI) about me as described below. I understand that if the person or entity that receives this information is not a health care provider, health plan, or health care clearinghouse who must follow the federal privacy standards, the health information disclosed as a result of this authorization may be re-disclosed by such person or substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Release Information To (Person/organization):_____
(Name)

_____ _____ _____
(Address) (City/State/Zip) (Area Code & Fax Number)

Person/Organization Providing Information:_____
Information authorized for use/disclosure or to be obtained should include the following:

□ **Psychotherapy Notes** (This is the only item you may request on this authorization. You must submit another authorization for other items below)
□ Medical information of this patient compiled between: _____ and _____
□ All medical information concerning this patient (excluding psychotherapy notes)

□ Face Sheet	□ Operative Report(s)	□ Pathology Report(s)
□ ER Record(s)	□ Radiology Report(s)	□ Lab Report(s)
□ Discharge Summary	□ Progress Notes	□ Radiology Film(s)
□ History & Physical	□ Physician Orders	□ EKG's
□ Consultation(s)	□ Other _____	

This information will be obtained, used, or disclosed for the following purposes(s) only:

□ Personal Use	□ Legal investigation/Action	□ Patient's /Legal Representative's Request
□ Continued Care	□ Insurance Eligibility/Benefits	□ Other: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information._____(Initials) If not applicable, check here □

I understand:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this document at anytime by presenting written revocation as provided in the "Notice of Privacy Practices".
4. I may revoke this authorization by notifying the hospital in writing at any time, except that revocation will not apply to information already used or disclosed in response to this authorization,
5. I have the right to inspect the health information to be released.
6. This authorization expires **90 days** after the date of the consent. If this authorization is for use of disclosure of protected health information for research, the authorization will expire at the end of the research study.
7. **"The Information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease."**
8. I receive a copy of this form after I sign it.
9. Copies of medical records will be provided for a reasonable fee. **Copies are $1.00 for the first page and 0.50 cents for each page thereafter.**
10. I release Southwestern Medical Center, its agents and employees from any liability in connection with the use or disclosure of protected health information (PHI).

Notice of Rights: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosures to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers, or disclosures for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from you which could be identified unless disclosure of that identifying information is authorized by you, or by an order or the courts, or by the Department of Health, or by law.

Signature of Patient (or Pt's Representative): _____ Date: _____

Name and Relationship of Patient's Representative: _____

Signature of SWMC's Representative: _____ Date: _____

SWMC Southwestern Medical Center

Authorization for Disclosure of Protected Information

Patient Label