Authorization for Release of Health Care Information

SIDNEY HEALTH CENTER

PATIENT IDENTIFICATION:

____
Patient Name (please print full name)

Address: ____

____

____
Previous/Maiden Name

Date of Birth: ______________________________

Telephone No.: ______________________________

AUTHORIZES RELEASE FROM: **(please be specific)**

____
Person/Agency/Facility Name

Address:____

____

Phone #: ____

DISCLOSE INFORMATION TO:

____
Person/Agency/Facility Name

Address: ____

____

Phone #: ____

DESCRIPTION OF INFORMATION TO BE RELEASED (including date(s) of service):

____

____

PURPOSE OF DISCLOSURE:
___Continued health care ___ Patient request ___ Other:________________________________ (please specify)

EXPIRATION DATE: This authorization is good until _______________________. If no date is specified, this authorization will expire 6 months from the date of signature unless withdrawn earlier in writing as explained below.

DISCLOSURES REQUIRING SPECIAL CONSENT (if applicable): My signature below specifically authorizes the release of health care information relating to the testing, diagnosis, or treatment for:

☐ HIV/AIDS Virus ___________________________ ☐ Sexually Transmitted Diseases __________________________
☐ Mental Health/Psychiatric ____________________ ☐ Drug, Alcohol Abuse/Treatment ______________________

~~~~~~

AUTHORIZATION: I authorize the release of information as described above. I understand that I may withdraw this authorization at any time. If I withdraw this authorization, I must do so in writing and present my written withdrawal to the Health Information Services (Medical Records) department at Sidney Health Center. My withdrawal will not apply to information that has already been released in response to this authorization. I understand that once the above information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that authorizing the use or disclosure of information identified above is voluntary. Sidney Health Center will not withhold treatment if I refuse to sign this authorization.

____ ____________________
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to Patient is:
____ Parent of Minor ____ Guardian ____ Next of Kin ____ Health Care Power of Attorney

Original: SHC; Copy to patient *Completed by:* ______________________________*MR#:* ________________
~~~~~~