Animas Surgical Hospital

Authorization for Disclosure of Patient Health Information

Eff. 10/2006
Rev. 11/2018

PATIENT NAME:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:

Animas Surgical Hospital Medical Records Fax: 970-385-2389
Email Address: mr@animassurgical.com

I authorize Animas Surgical Hospital the use or disclosure of my protected health information as described below.
Animas Surgical Hospital is authorized to make disclosures to: ☐ Patient ☐ Other, individual or organization

Name:	
Address:	
City/State:	
Phone Number:	**Fax Number:**

PURPOSE OF THE RELEASE: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other:_____

Date of Service(s) _____ to _____

The extent or nature of information to be released:

☐ Face Sheet	☐ Imaging Reports	☐ Entire Record
☐ Emergency Room Record	☐ Operative Report	☐ EKG
☐ Lab Results	☐ Pathology Report	☐ Other, please specify _____

☐ Imaging PowerShare Enrollment **Email:**_____

PATIENT ONLY:
☐ I request a copy of an accounting of the uses and disclosures of protected health information. The first accounting within a twelve (12) month period is free of charge, any additional request will be charged as listed above.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire ninety (90) days from the date of signing below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in section CFR 164.524 of the Health Insurance Portability and Accountability Act. I understand that if the person or entity authorized to receive the information is not a healthcare provider or health plan the released information may no longer be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Services

Signature of Patient or Legal Representative — Date

If signed by Legal Representative, Relationship to Patient — Date

_____ Date information released
_____ Initials of individual making disclosure

_____ Enrollment Date
_____ Initials of staff completing PowerShare enrollment