Authorization for Disclosure of Patient Health Information

Eff. 10/2006
Rev. 05/2019

Release of Information May be Incomplete if Medical Record is Released Within 30 Days of Patient Encounter
Animas Surgical Hospital Medical Records Phone 970-385-2395 Fax: 970-385-2389

PATIENT NAME:	**DATE OF BIRTH:**

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

I would like my records: ☐ Mailed to below ☐ Faxed to below ☐ Will pick up ☐ Emailed to below

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

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 ☐ Imaging Disc, please specify: _____
☐ 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 _____ Enrollment Date

_____ Initials of individual making disclosure _____ Initials of staff completing PowerShare enrollment