EFFINGHAM HEALTH SYSTEM®

Authorization for Use and Disclosure of Protected Health Information

This authorization outlines disclosure of my individually protected health information for purposes other than those that are outlined in the Privacy Rule for treatment, payment and health care operations. By signing, I am agreeing to disclosure of my health information voluntarily. I further understand that once disclosed, this information may be re-disclosed by the recipient and no longer protected under the Privacy Rule.

Name	Medical Record Number	Account Number

Date of Birth	Social Security Number

I, _____(Patient/Resident/Personal Representative) authorize

_____to disclose and release my specified protected health information
(*Facility Name*) as indicated below:

Please release to (Please include name and address):

_____

_____

_____

_____

Please check reason: ___Attorney ___Insurance ___Medical ___Personal Disability

Release format: Electronic Request ____(CD only) Paper Request___

I authorize release of the following information to the address above:

	Specific Information:	From Date:	To Date:
_____	Copies of all records for the period	_____	_____
_____	Copy of history and physical exam	_____	_____
_____	Copy of lab reports	_____	_____
_____	Radiology reports	_____	_____
_____	Billing records	_____	_____

For Original Film Release Only If applicable:

_____

Name of facility/physician Name released to

_____

Address of requesting facility/physician

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This disclosure is being made at the request of:

_____

Please indicate name and relationship of requestor

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for:

1. Alcohol, drug abuse, or dependency;
2. Psychiatric or psychological, mental illness or retardation; or
3. Acquired immune deficiency syndrome (AIDS).

Please initial if you are placing **NO** limitations _____

The facility may not condition treatment, payment, enrollment or eligibility as consequences for not signing this authorization except for those reasons as are outlined in the Privacy rule, i.e., claims, billing and insurance of and for the individual.

The release in any manner of all information is authorized by my signature and I do hereby release all persons, agencies, firms, companies, etc., from any damages resulting from providing such information.

I understand that I may receive a copy of this authorization and an additional copy will be maintained by the facility.

This authorization is valid for 1 year from the date of my signature above, unless otherwise noted.

I understand that I may revoke this request at any time by submitting a request for revocation in writing to the facility Privacy Officer or Designee. I further agree that I may not hold the facility or recipient liable for any use or disclosure that may have occurred prior to receipt of my revocation.

Document type of Photo ID checked: _____

Signature	Date/Time
Printed Name	Relationship
Signature of Witness	Date/Time
Title/relationship of witness	

For Original Film Return Only:

Signature of receiving personnel	Date/Time received