Unity MEDICAL CENTER
For Your Health

(Office use only) MRN: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____

Maiden/Previous Names: _____

Release Information From:

Name/Facility:
Address:
City/State/Zip
Phone:

Release Information To:

Name/Facility:
Address:
City/State/Zip
Phone:

Information to be Released:

□ Discharge Summary
□ History and Physical
□ Emergency Room Record
□ Consultation
□ Progress notes
□ Other _____
□ Immunization Record
□ Laboratory reports
□ X-ray reports □ X-ray films □ X-ray CDs
□ Clinic physician visit notes
□ Billing information
□ Complete record (Hospital or Clinic). Please circle record type needed. (One year history unless otherwise specified)

For the following date(s) of treatment or condition:_____

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records:

□ Psychiatric/Psychological _____ Initials
□ HIV _____ Initials
□ Drug and/or Alcohol Dependency _____ Initials

Delivery Time Frame: **Date information desired by:** _____

Purpose: □ Continued care □ Personal use □ Other _____

This authorization shall remain in effect until the following date, event or condition: _____.
If no date, event or condition is specified, this authorization will expire in one year.

Release Format:

_____Oral _____Written _____USB _____FAX _____(Continued Care Only) Fax Number: _____ _____My Health

1. This information remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

_____ _____
Signature (required) **Date Signed (required)**

_____
Printed Name of Person Signing (f not patient)

Revised 12/16