# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name_____ Date of Birth _____

Address_____ Phone_____
Street City State Zip

☐ Please process this authorization now. ☐ Please keep this authorization on file for possible disclosure later.

**I AUTHORIZE:** ☐ Madison Memorial Hospital ☐ Madison Surgery Center ☐ Madison Memorial Rexburg Medical Clinic
☐ Madison Memorial Orthopedics ☐ Seasons Medical by Madison Memorial ☐ _____

**TO DISCLOSE TO:** _____

_____
Address City State Zip code Fax Number

**The following type(s) of information per this authorization:**

☐ **Any information concerning the patient's health, health care, or payment during the relevant time period.**
☐ **Only the following health records from the relevant time period:**

| | | | |
|---|---|---|---|
| ☐ History & Physical | ☐ Last PO Intake | ☐ Radiology Reports | ☐ ALL |
| ☐ Nurses Notes | ☐ Operative Report | ☐ Radiology Images | |
| ☐ Pathology Report | ☐ Discharge Summary | ☐ EKG | |
| ☐ Physician's Progress Notes | ☐ Physician's Orders | ☐ Lab Reports | |
| ☐ Emergency Room Record | ☐ Consultation Report | ☐ Office Notes | |

☐ **Billing and payment records for care rendered during the relevant time period.**
☐ **Other:** _____

**Records or Information relating to the following time period:**

☐ The patient's health care at anytime.
☐ The patient's health care between *(date)* _____ and *(date)* _____.

**PURPOSE or NEED FOR RECORDS:**

| | |
|---|---|
| ☐ Personal | ☐ Treatment/Continuing Medical Care |
| ☐ Insurance | ☐ Disability Request |
| ☐ Legal/Attorney/Subpoena | ☐ Other (specify) _____ |

**FORMAT I would like to receive my copies of the items checked above in the following format:**

| | | |
|---|---|---|
| ☐ Paper format (US Mail) | ☐ CD (MMH only) | ☐ Fax (Healthcare Provider only) |
| ☐ Paper format (pickup) | ☐ Review Only | ☐ Email_____ |

**SENSITIVE NATURE RECORDS: The individual signing this authorization expressly authorizes Madison Memorial Hospital to disclose information (diagnosis/treatment) regarding behavioral/mental health conditions (excluding psychotherapy notes), drug, alcohol, or substance abuse, HIV/AIDS, sexually transmitted diseases, communicable diseases, and genetic marker information.**

I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. 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 one year from the date this authorization is dated. I need not sign this form in order to assure treatment. I understand that once protected health information is disclosed to others, the protected health information may be disclosed to individuals or organizations not subject to the Health Insurance Portability and Accountability Act and may no longer be protected by HIPAA.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, state legal relationship to patient & reason for representation. Signature of Witness

**Facility Use Only:** ☐ Authorizer's ID Verified | ☐ ID of 3rd Party Receiving Records Verified | Completed by: _____

Records requested from: _____ Phone: _____ Fax: _____

Address: _____ City _____ State _____ Zip _____

**Date released:**_____ / _____ / _____ ☐ **Info already released** ☐ **Needs to be released** ☐ **Copy of ROI to Patient**