Touchette Regional Hospital

RELEASE OF PROTECTED HEALTH INFORMATION AND DISCLOSURE AUTHORIZATION

Having been fully informed of the circumstances in connection with the request for information from my clinical record, I hereby authorize & request Touchette Regional to release and disclose the following protected health information:

PATIENT NAME: _____ **DATE OF BIRTH:** _____

☐ Verbal Release

(Last, first, initial) (MM/DD/YYYY)

Patient unable to sign

(Circle One)

(Unresponsive)

Release to: Name: _____ ☐I consent to my photo being Taken for release of records.

Address: _____

_____

Phone/Fax Number: _____

Obtain from: Name: _____

Address: _____

Phone/Fax Number: _____

DISCLOSURES:

Hospitalization Dates: _____

Purpose of disclosure :(Check One)

☐Insurance Claim ☐Medical ☐Personal ☐Legal Counsel ☐Investigative ☐D**isability ☐Other: (Please Specify)**_____.

I specifically request the release and disclosure of the following protected health information:

☐Face Sheet ☐Newborn Data Sheet ☐Consultation ☐Discharge Summary ☐Surgical/Delivery Report

☐History/Physical ☐Physician's Orders/Notes ☐Laboratory/Pathology Report ☐Physical Therapy

☐Ultrasound/Sonogram/X-ray/Scans (CAT, Brain, Lung etc) and/or films

☐ EKG/Echo Reports/Stress Test/24-Hour Holter Monitor

☐Respiratory (Pulmonary) Therapy ☐Emergency Room ☐Nurses' Notes ☐Complete Records

☐Other :(Please Specify)

_____

DISCLOSURES REQUIRING SPECIAL AUTHORIZATION PLEASE INITIAL:

Alcohol/Drug Abuses, _____Sexually transmitted diseases/HIV results, _____and any psychological assessments _____.

ATTENTION: Once the above information has been released pursuant to this Authorization it may not longer be protected by Federal and/or State law or regulations; and may no longer be deemed "CONFIDENTIAL".

Signature below acknowledges that I understand:

- I may revoke this authorization in writing at any time with the exception to the extent that action has been taken on this authorization.
- I further understand that this authorization shall expire without my express revocation, ninety (90) days from the above date.
- I understand that I am voluntarily signing this authorization, that I have the right to refuse to sign this authorization and that the information that is released will no longer be protected under the federal privacy laws.
- I have a right to request a copy of this authorization, inspect or obtain a copy of the information to be disclosed and that Touchette Regional Hospital may assess reasonable fee that comply with the federal and state laws.

SIGNATURES: I agree to the above information and authorize Touchette Regional Hospital to disclose the above information to the designated individuals.

Patient/Legal Guardian Signature:_____

Date_____

If authorizing signature is not that of patient indicate legal relationship to patient: _____

Witness: Name: _____Date_____

Medical Record Use Only: TRH Correspondence Employee, _____ (618-332-5423)

Number of Pages: _____Charges_____Amount Paid_____ Date Sent_____

Physician(s)' name(s):

_____

Please forward completed authorization or correspondence to TRH Health Information Dept at the address above.
HI#001
07/10