**TOUCHETTE REGIONAL HOSPITAL**

**RELEASE OF PHI (PROTECTED HEALTH INFORMATION) & 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:** _____ (Last, first, initial) (MM/DD/YYYY)
Patient unable to sign: Unresponsive Verbal Authorization
I consent to my photo being taken for release of records. **Initial here**_____

**Release to:** Name: _____
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 : (PleaseSpecify):**_____

**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_____
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.**