AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

1. **I AUTHORIZE**:

Chester River Hospital Center

2. **TO RELEASE TO**:

_____
Name of Receiving Person or Organization

_____
Street Address

_____
City, State, Zip Code

3. **INFORMATON TO BE RELEASED**: (Check all applicable)

HISTORY&PHYSICAL	NURSING NOTES	RESPIRATORY THERAPY
DISCHARGE SUMMARY	ORDERS	EMERGENCY DEPARTMENT
OPERATIVE REPORTS	CONSULTATIONS	OUTPATIENT SURGERY
PATHOLOGY REPORTS	EKG	RECORDS FROM
RADIOLOGY REPORTS	EEG	OTHER HOSPITALS
LABORATORY REPORTS	PHYSICAL THERAPY	ENTIRE RECORD
PROGRESS NOTES	OCCUPATIONAL THERAPY	OTHER_____
		OTHER_____

4. **RECORDS FROM THE TIME PERIOD(S)**:____/____/____**TO**____/____/____
____/____/____**TO**____/____/____

SPECIAL AUTHORIZATION FOR DRUG AND ACOHOL TREATMENT RECORDS:
I specifically authorize the disclosure of informaton pertaining to drug and alcohol treatment_____
(initials)

5. **THE PURPOSE OF THIS DISCLOSURE IS**:

CONTINUED MEDICAL CARE	PAYMENT OF INSURANCE CLAIM	LEGAL
PERSONAL	WORKERS' COMP CLAIM	OTHER_____

6. **DURATION OF AUTHORZATION**: UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION IS VALID UNTIL ____/____/____ OR FOR A PERIOD OF ONE YEAR, WHICHEVER IS LESS.

7. **BY SIGNING BELOW, I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING:**

- That I may revoke this authorization at any time by presenting a written revocation to the Director of Medical Records for Chester River Hospital Center.
- That I do not have the right to revoke this authorization if it was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy itself.
- That any revocation will not apply to information that already has been released in response to this authorization.
- That information released pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.
- That Chester River Hospital Center will not condition treatment on my signing this authorization unless (1) I am enrolled in a research study and the treatment is part of the study, or (2) the sole purpose for the provision of health care is to disclose health information to someone else.
- That the fees for copying and mailing the information have been explained to me and I understand that I will be responsible for the costs of copying and mailing.
- That if I have any questions about disclosure of my protected health information, I may contact the Medical Records Department.

_____	_____
Patient's Name (at time of treatment)	Patient's Social Security Number
_____	_____
Street Address	Patient's Date of Birth
_____	_____
City, State, Zip Code	Daytime Phone Number
_____	_____
Patient's or Representative's Signature	Date
_____	_____
Printed Name of Patient's Representative(if applicable)	Basis of Representative's Authority (if applicable)