MMH
MUENSTER MEMORIAL
HOSPITAL

Patient Name:
Med Rec Number: Acct Number:
Age: Gender: DOB: Svc Date:

Authorization for Use or Disclosure of Protected Health Information

(THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR 1 YEAR).

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____

Sex _____ Date of Birth / / Social Security Number - - Telephone Number ( ) -

Street Address _____ City _____ State _____ Zip Code _____

I hereby authorize the release of copies of my medical records concerning my illness, treatment or recommendations while I was a patient at the medical facility, **during the dates of:** _____

These records should be released:

TO:

Name: _____ Phone # ( ) - Fax # ( ) -

Street Address: _____ City _____ State _____ Zip Code _____

FROM:

Name: _____ Phone # ( ) - Fax # ( ) -

Street Address: _____ City _____ State _____ Zip Code _____

I request the following information be released:

- ❑ Discharge Summary
- ❑ History and Physical
- ❑ Progress Note
- ❑ Operative Notes
- ❑ Pathology Reports
- ❑ Laboratory Reports
- ❑ Radiology Reports
- ❑ ECG/EEG/Cardiac Cath
- ❑ Emergency Reports
- ❑ Other (please list): _____

Please check the following specific authorizations: [Required by law]:

AIDS/HIV and other Communicable Disease	❑ I DO authorize	❑ I DO NOT authorize
Alcohol and/or Drug Abuse Treatment	❑ I DO authorize	❑ I DO NOT authorize
Mental Health Services	❑ I DO authorize	❑ I DO NOT authorize

(Mental Health Services Provided by: A clinical nurse specialist; Psychologist; Social Worker; counseling professional; or a physician specializing in psychiatry licensed under the provision of Title 32.)

Purpose of disclosure:

- ❑ Referral to Specialist
- ❑ Change of Doctor
- ❑ Continuing Care
- ❑ Insurance
- ❑ Legal Investigation
- ❑ Disability Determination
- ❑ Worker's Comp
- ❑ Personal
- ❑ Other (please list): _____

I hereby authorize the use or disclosure of individually identifiable health information for the above named patient as described above. I understand that this authorization is voluntary and that I may refuse to sign the authorization. I may cancel this request with written notification, but it will not affect any information released prior to notification of cancellation. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other covered entity associated with the practice where I am seeking care, the released information may no longer be protected by federal privacy regulations.

Click here to sign
_____ _____

Patient Signature **Date Completed**

AUTHDISC