Authorization for Disclosure of Health Information

Please note: Sections with * must be completed for this form to be processed

The Richland Hospital
and clinics

*PATIENT INFORMATION

Name	Date of Birth	Phone Number
Street Address	City/State/Zip	Email

****Authorizes Disclosure By: (Records Sent From)***

- ☐ The Richland Hospital & Clinics
- ☐ Other Facility:______________________

Address:_________________________________

City/State/Zip:___________________________

Phone:____________________Fax:__________

****Authorizes Disclosure To: (Records Sent To)***

- ☐ The Richland Hospital & Clinics
- ☐ Facility/Patient/Other:______________

Address:_________________________________

City/State Zip:_____________________

Phone:____________________Fax:__________

Email:__________________________________

PREFERRED DELIVERY METHOD: ☐ Mail ☐ Email ☐ Fax ☐ Pickup

***INFORMATION TO BE DISCLOSED:** Identify below the specific information to be disclosed along with relevant dates of service; this information may include history and physical reports, discharge summaries, clinical notes, diagnostic studies, etc.

- ☐ Hospitalizations (if Within Last Year)
- ☐ Most Recent Colonoscopy
- ☐ Vaccination Records
- ☐ Most Recent Mammogram
- ☐ Laboratory Reports (if Within Last Year)
- ☐ Emergency Dept. Reports
- ☐ Most Recent Annual Wellness/ Physical Exam/Progress Notes
- ☐ Other_____________________

***DATES OF SERVICE REQUESTED** _______/_______/_______**TO**_______/_______/_______

***PURPOSE FOR DISCLOSURE: Please provide specific purpose for disclosure.**

- ☐ Further Medical Care
- ☐ Application for Insurance
- ☐ Disability Determination
- ☐ Payment of Insurance
- ☐ Personal Use
- ☐ Legal Investigation
- ☐ Other:______________ ____________________

****FEES: Please note that fees may apply as permitted by state and federal laws***

Please continue on back side of this page

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YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to inspect or receive a copy of the Health Information to be used or disclosed - I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form. Right to receive a copy of this authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to refuse to sign this authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use an/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to WITHDRAW this authorization - I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the disclosing organization. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. The Richland Hospital, Inc. will not condition treatment on the completion of this authorization. I understand that, once my health information leaves the control of The Richland Hospital Inc., it may be further disclosed by the receiving party. I agree that I will not hold The Richland Hospital, Inc. liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.

EXPIRATION DATE: This authorization is good until the following date(s)________________or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirmation that it accurately reflects my wishes.

***Signature of Patient/Legal Rep**____ Date_____________

(If signed by other than patient, state relationship and authority to do so.)

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of health information relating to the testing, diagnosis and treatment for:

☐ HIV/AIDS Virus ☐ Mental/Behavioral Health Conditions ☐ Drug/Alcohol Abuse/Treatment

***Signature of Patient/Legal Rep**____ Date_______________

(If signed by other than patient, state relationship and authority to do so.)

FOR ORGANIZATION'S USE

Date Received: ____/____/____ Date Disclosed: ____/____/____ Disclosed By: ______________________

☐ Mailed ☐ Emailed ☐ Faxed ☐ Picked Up By:______________________