Huggins Hospital
a member of GraniteOne Health

[PATIENT LABEL]

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name _____ Date of Birth _____ Email address _____

Mailing Address _____ City/Town _____ State/Zip _____Phone # _____

I authorize **Huggins Hospital**

☐ Send/Release information to: ☐ Receive information from:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Delivery Method: ☐ In person ☐ Mail ☐ Fax ☐ Email Email: _____

Check the type of information released/requested:

☐ Discharge Summary
☐ History & Physical
☐ Consultation
☐ Operative Report
☐ Emergency Dept. Visit
☐ **Other:**_____

☐ Progress Notes
☐ Laboratory Report
☐ Echo/EKG Report
☐ Radiology Report
☐ Physician Office Visit

☐ Physician Orders
☐ Progress Notes
☐ Medication Records
☐ PT/OT Rehab Notes
☐ Nurses' Notes

☐ Itemized Bill
☐ Ambulance Reports
☐ Immunization Records
☐ Entire Medical Record

Dates of care to be released: _____ to: _____

I UNDERSTAND THAT:

Huggins Hospital will treat me even if I decline to sign this authorization.

Upon request, I can inspect or obtain a copy of the information I am authorizing to be released.

Information disclosed under this authorization may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state laws.

I can revoke this authorization at any time by submitting a request in writing to the Huggins Hospital Health Information Management Services. This will not apply to any previously released information.

I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

☐ **The following types of information WILL NOT BE INCLUDED UNLESS indicated by you initialing below:**

Drug and/or alcohol treatment	**Initials: _____**	**Psychiatric/Mental Health**	**Initials: _____**
Abuse/sexual abuse	**Initials: _____**	**Genetic testing**	**Initials: _____**
Sexually transmitted disease	**Initials: _____**	**Reproductive Hx**	**Initials: _____**
HIV (AIDS) testing/treatment	**Initials: _____**		

This authorization expires six months from the date of signature, or on: _____

SIGN HERE_____ **DATE**_____

Signature of patient of legal representative