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Discovery Health Record Solutions • Authorization to Use or Disclose Protected Health Information (PHI)

I hereby authorize _____ to release information from the records of :

_____ : _____ : _____
Name of Patient | Date of Birth | Last four Digits of SSN

This information is to be released to: _____

_____

Records are being required for the purpose of: _____

Types of records to be released and approximate dates of service (check all that apply and treatment dates):

Outpatient Records: _____ Physician Offices/Clinic: _____

The following medicals records are to be released (check all that apply):

__ **ENTIRE MEDICAL RECORD (Includes all sections mentioned below):**

__ Billing Statements
__ Care Plans
__ Clinician office notes
__ Consultant Reports
__ Discharge Summary
__ EKG Reports
__ Emergency/Urgent Care Records
__ Labor and Delivery Records
__ Laboratory Reports
__ Mammography Report
__ Medical History/Physical Exam
__ Medication Records
__ Progress Notes
__ Operative Report
__ Pathology Report
__ Physician Orders
__ Psychiatric Evaluations
__ Psychiatric Records
__ Radiology Reports
__ Other _____

HIV, Mental Health, and Drug & Alcohol Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:

___ HIV ___ Mental Health (Psychiatric) ___ Drug & Alcohol

This authorization will expire in 1 year unless I otherwise indicate here: _____

My signature below indicates that: I have read and understood this information: I can request to receive a copy of this form. I am the patient, and/or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated forms. Please see below for additional patient rights and responsibilities.

Patient's Signature: _____ Date: _____

Patient's Printed Name: _____

Patient Email Address (required for electronic delivery/please print clearly): _____
(DHRS will send patient email to set up with electronic delivery to patient through StatusNOW tracking system)

Representative's Signature: _____ Relationship to Patient: _____

Representative's Printed Name: _____ Date: _____

Please see reverse side of form for additional patient rights and responsibilities

Additional Patient Rights and Responsibilities

- Treatment cannot be withheld if the patient refuses to sign the Authorization.
- The law requires that a disclosure statement will accompany medical records.
- The form dictates what records will be released, and for what purposes; no items will be released if they have not been listed or otherwise indicated on this form.
- Discovery health Record Solutions is neither liable nor responsible for any re-disclosure of records once they are received by the organization/person/facility that makes the request.
- A patient may revoke this authorization at any time by sending a written request to the entity authorized to release the information.
- A patient's decision to revoke the Authorization is not retroactive; it does not apply to any release of his or her records which may have taken place prior to the date of the revocation of the Authorization.
- The decision to revoke the Authorization may result in the patient's insurance company's not being able to authorize payment for medical care: It must be understood that the patient may be responsible for payments of any and all claims filed.
- The patient is entitiled to a copy of his or her completed Authorization form.
- A faxed copy of this authorization shall serve in lieu of the original.