



BSR-MR-50 (1/21)

## **AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Entire Record	(Patient's Full Legal Name)		(DOB)		(Day Phone #)	
To Disclose THE FOLLOWING INFORMATION:    Abstract of Record	Address:		City:	State:	Zip:	
To Disclose THE FOLLOWING INFORMATION:    Abstract of Record	I, Authorize:					
Abstract of Record	,	(Name of Hospital	or Physician Practice to Disclose Inform	nation)		
Abstract of Record	To Disclose the Following I	NFORMATION:	Date of Visit:			
ED Record	☐ Abstract of Record	☐ Anesthesia Record			☐ MyChart Communication	
ED Record	☐ Entire Record	☐ X-rays or Imaging Report	☐ Discharge Summary	Other:	Other:	
Recipient Name:  Address:  Fax (healthcare provider only):  Disclosure Format (Paper is default if not marked):  US Mail  Electronic format: CD/DVD  Radiology Film/CD  MyChart  e Delivery by Ciox (for patient's only) - email address:  Purpose of Disclosure:    Physician   Insurance   Legal   Other (Please special polisability Determination   Personal   Worker's Compensation  Authorization to Release Information:  1. I understand that I am giving my permission to disclose confidential health care records, unless indicated beliapplicable, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunode It may also include information about behavioral or mental health services and treatment for alcohol and drug Special Instructions:  2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization from in order to ensure treatment. I understand that I may inspect or copy the information to be used or discloser 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information.  3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization in understand that the revocation will not apply to inform already been released in response to this authorization. I understand that the revocation will not apply to my insurance law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorizatio from the date of signature.  4. I understand that copying charges will be applied, according to the hospital policy.  Signature of Patient or Legal Representative	☐ ED Record	☐ Laboratory Results	☐ Immunization Record			
Address:	Disclose Information to:					
Disclosure Format (Paper is default if not marked):  US Mail   Electronic format: CD/DVD   Radiology Film/CD   MyChart     e Delivery by Ciox (for patient's only) - email address:  Purpose of Disclosure:   Physician   Insurance   Legal   Other (Please special Disability Determination   Personal   Worker's Compensation    Authorization to Release Information: 1. I understand that I am giving my permission to disclose confidential health care records, unless indicated beleapplicable, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunode It may also include information about behavioral or mental health services and treatment for alcohol and drug Special Instructions:  2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclose 144.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information. I organization above disclosing the information.  3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization are involved in the date of signature.  4. I understand that copying charges will be applied, according to the hospital policy.  Signature of Patient or Legal Representative	Recipient Name:					
Disclosure Format (Paper is default if not marked):    US Mail   Electronic format: CD/DVD   Radiology Film/CD   MyChart     e Delivery by Ciox (for patient's only) - email address:    Purpose of Disclosure:   Physician   Insurance   Legal   Other (Please special Disability Determination   Personal   Worker's Compensation    Authorization to Release Information: 1. I understand that I am giving my permission to disclose confidential health care records, unless indicated beliapplicable, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunode It may also include information about behavioral or mental health services and treatment for alcohol and drug    Special Instructions:	Address:		City:	State:	Zip:	
□ US Mail □ Electronic format: CD/DVD □ Radiology Film/CD □ MyChart □ e Delivery by Ciox (for patient's only) - email address: □ Purpose of Disclosure: □ Physician □ Insurance □ Legal □ Other (Please special Disability Determination □ Personal □ Worker's Compensation □ Understand that I am giving my permission to disclose confidential health care records, unless indicated behapplicable, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunode It may also include information about behavioral or mental health services and treatment for alcohol and drug Special Instructions: □ 1 understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization is form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclose 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I organization above disclosing the information.  3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization already been released in response to this authorization. I understand that the revocation will not apply to my insurant law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorizatio from the date of signature.  4. I understand that copying charges will be applied, according to the hospital policy.  Signature of Patient or Legal Representative	Fax (healthcare provider of	only):				
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<ol> <li>I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclose 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I corganization above disclosing the information.</li> <li>I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization writing and present my written revocation to the facility. I understand that the revocation will not apply to informalize along been released in response to this authorization. I understand that the revocation will not apply to my insurance law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization from the date of signature.</li> <li>I understand that copying charges will be applied, according to the hospital policy.</li> </ol> Signature of Patient or Legal Representative	It may also include info	mation about behavioral or me	ntal health services and treatm	ent for alcohol and	drug abuse.	
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Signature of Patient or Legal Representative	so in writing and present already been released in law provides my insurer v	my written revocation to the facili response to this authorization. I u vith the right to contest a claim ur	ity. I understand that the revocation wi	on will not apply to in Il not apply to my ins	formation that has urance company when the	
	4. I understand that copying	charges will be applied, accordi	ng to the hospital policy.			
	Signature of Patient or Lega	al Representative				
If signed by legal representative, relationship to patient:					DATE/TIME	
DEPARTMENT USE ONLY						
	D				FIED SIGNATURE VERIFIEI	