Maury Regional Health*

Authorization to Release Protected Health Information

Patient Name:_____ Birth Date:_____ Last 4 digits of S.S. #_____

Address:_____ Phone #_____

I request and authorize: _____

☐ **To Release my health information to:** _____
(Myself or the Name and Address of Recipient– Specify: Attorney, Insurance, etc.)

☐ **To Obtain my health information from**: _____
(Name and Address – Specify: Hospital, Physician, etc.)

PURPOSE: ☐Further Care ☐Legal ☐Insurance ☐Payment or Billing ☐Personal Use ☐Social Security/Disability

Date(s) of treatment to be released: _____to:_____ (enter specific date or dates)

Information to be released: ☐Lab Reports ☐Imaging (X-ray) Reports ☐ER Records ☐Billing ☐Other _____
☐Medical Record Abstract (History & Physical, Discharge Summary, Consults, Operative Report, and Pathology, if applicable)

I would like: ☐Paper copies ☐Copies on a CD ☐ Copies on a USB flash drive ☐an electronic file emailed** to me at:

Email address: _____

I understand that:

- I do not have to sign this authorization in order to receive treatment, payment or to be eligible for benefits.
- the release of my information may include information regarding diagnosis and/or treatment from other facilities or providers.
- this authorization will remain in effect for **ninety (90) days** after the date recorded below.
- this authorization can be taken back (revoked) at any time with a written request to the HIM Department (Medical Records).
- revoking this authorization stops further release but cannot undo any release of information that may have already occurred.
- once the information is released because of this request, it could be released by the recipient and the information may no longer be protected by federal privacy regulations.
- sending an unencrypted or unsecured email poses the risk of the file being viewed by unknown persons through the internet. **The records will be emailed in a secure/encrypted manner unless instructed otherwise.

- **I also understand that my records may include information regarding the diagnosis or treatment for alcohol and/or drug abuse; psychiatric or mental illness; and/or sexually transmitted diseases (STDs), as well as AIDS or HIV information <u>AND</u> that I can limit the release of this type of information.**
- My signature below authorizes the facility specified above to furnish or obtain the information specified above even though the confidentiality of the information may be protected by Federal and State law and regulations.
- The facility is hereby released and discharged of any liability, and I will hold the facility harmless for complying with this authorization.

_____ _____ _____
Printed Name of Patient or Authorized Individual | Signature of Patient or Authorized Individual | Date and Time of Signature

(If the above signature is not that of the patient, please explain why. Documentary evidence of guardianship may be required to accompany this form.)

_____
Relationship to patient and/or description of authority to act for the patient

Photo ID was provided: □*Yes* □ *No - If No, specify form of patient identification:* _____

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**Maury Regional Health brand is representative of Maury Regional Hospital d/b/a Maury Regional Medical Center, Maury Regional Hospital d/b/a Marshall Medical Center, Maury Regional Hospital d/b/a Wayne Medical Center, and Maury Regional Medical Group, Inc.*