



PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Address: _____

MR# _____ DOB: _____ SS# _____

I authorize the use of disclosure of the above named individual's health information as described below.

The following organization is authorized to make the disclosure:

Hocking Valley Community Hospital
601 State Route 664 North
P.O. Box 966
Logan, Ohio 43138

Dates of service: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> ED |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Clinic |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> MRI | <input type="checkbox"/> X-ray films |
| <input type="checkbox"/> Labs | <input type="checkbox"/> Consultations | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Entire Record | |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Disclosure Log | |

Other: (Please describe) _____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to, and used by, the following:

Name: _____
Address: _____

This information is being disclosed for the following purpose(s): _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to authorized Medical Record personnel at Hocking Valley Community Hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

(over)

This authorization will expire on _____
If no date is indicated, authorization will expire ninety (90) days from the date signed.

If you have questions about disclosure of your health information, contact the supervisor of the Medical Record Department at Hocking Valley Community Hospital.

You will be given a copy of this authorization form after signing.

If you wish for someone else to pick up your records, please indicate:

Name: _____ Relationship: _____

Signature of patient: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

If signed by Legal Representative, relationship to patient: _____

Signature of Witness: _____ Date: _____

THERE IS A CHARGE FOR COPYING MEDICAL RECORDS FOR PERSONAL USE AND FOR ATTORNEYS.

\$5.00 Pull fee
\$1.00 per page up to 10 pages
\$0.25 per page for pages 11-1000