AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (PLEASE PRINT):	**Birth Date:**	**SS No.:** **(Last 4 digits only)**
	Drivers License No. (only required if you are NOT requesting records in person):	
	E-Mail Address:	

Information Being Released by:

Release Records To:	Address:	City:	
	Telephone No.:	State:	Zip:

Purpose of Disclosure: ☐ Medical Care ☐ Insurance ☐ At the Request of the Patient ☐ Patient Portal Access ☐ Other, Please Explain:

Method of Disclosure: ☐ Paper ☐ Facsimile ☐ Password Protected CD or DVD ☐ Other:_____

☐E-mail: Secure/Encrypted or Unsecure/Unencrypted: Note if sending **unsecured/unencrypted** e-mail over the internet, there is some level of risk that the information could be read or otherwise accessed by a third party while in transit. Please initial here that you wish to send unencrypted:_____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

Dates of Treatment:	**Place of Treatment:** ☐ Inpatient ☐ Emergency Room ☐ Outpatient ☐ Other (specify):

Choose from the following (please initial beside documents):

_____	**All Dictated Reports**	_____	Lab (may include AIDS/HIV information)	_____	History & Physical
_____	**Radiology Reports**	_____	Pertinent Summary	_____	Discharge Summary
_____	**Pathology Reports**	_____	ER Record	_____	Consultation
_____	**Anesthesia Record**	_____	Billing Record	_____	Operative/Procedure Report
_____	Entire Chart	_____	Photographs/Images	_____	Other (specify):

I understand that:

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
5. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
6. My signed (written) authorization will expire in ninety (90) days unless I provide an alternate expiration date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed. Patient Portal access will expire upon termination of Portal account.
7. If the facility will use or disclose my protected health information for marketing purposes, the facility will not receive remuneration or compensation for such use or disclosure for marketing purposes unless the WTH Privacy Coordinator completes and signs the following statement:

I, _____ (signature of WTH Privacy Coordinator) hereby certify that JMCGH will receive remuneration or compensation for the use or disclosure of this patient's protected health information from _____ (fill in source of remuneration or compensation).

I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above-requested protected health information about me.

Signature of Patient	Signature of Patient's Authorized Representative

Date	Description of Representative's Authority to Act for Patient	Telephone Number