Authorization for Release of Information

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR MEDICAL RECORDS UNDER THE PROTECTION OF STATE AND FEDERAL LAW (INCLUDING BUT NOT LIMITED TO: DRUG, ALCOHOL, PSYCHIATRIC, SEXUALLY TRANSMITTED DISEASES, OR HIV RELATED TREATMENT).

I, _____ the undersigned, hereby authorize

_____
(Name of Specific Person/Organization/Institution)

_____
(Complete Address)

TO RELEASE the following information from my medical records pertaining to:

_____
(Indicate: specific dates, types of information, extent of information or all information)

Purpose of disclosure: _____

The above information may be released to: _____
(Organization/Person receiving information)

_____
Address City State Zip Code

I understand that I may revoke this authorization at any time by submitting a request in writing to the Health information Management (Medical Records) Department of Regional One Health (ROH), as stated in our Notice of Privacy Practices; however, I also understand that any information which has been disclosed prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, or occurrence of such event or condition, this authorization to release information shall expire:

_____
(state: date, event, or condition of expiration)

I understand that Regional One Health will not withhold care or treatment if I do not sign this authorization unless:

1. The treatment is related to research and this authorization allows ROH to release information to the researcher, **or**
2. The only purpose of the treatment is to provide information to a third party, and this authorization allows ROH to release the information to the third party.

I understand that it is possible that the information released pursuant to this authorization may be redisclosed by the recipient because it is no longer protected by ROH or by privacy laws.

I hereby state that I have read and fully understand the above statements as they apply to me.

Signature of Patient: _____ Date: _____

(If patient either is under legal age or has a guardian appointed by the court, this release must be signed by the patient's parent or guardian.)

Signature of Parent/Guardian: _____ Date: _____

Relationship to Patient: _____

Signature of Witness: _____ Date: _____

Regional One Health

Authorization for Release of Information

Affix Patient Label

Form No. ROH.246 (Rev. 02/15) *RO0001*

Authorization for Release of Information

Identifying Information

Patient Name: _____ Chart Number: _____

Address: _____ Phone Number: (_____) _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Social Security Number: _____ - _____ - _____

Mother's Maiden Name: _____ Father's Name: _____

Regional One Health

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Affix Patient Label

Form No. ROH.246 (Rev. 02/15) *RO0001*