United Health Services

Chenango Memorial Hospital

RELEASE OF PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Patient's Name _____ Date of Birth _____
Please Print

Patient's Address _____

Phone # _____ Fax # _____

I hereby authorize use or disclosure of the above named individual Health Information as described below.

1. The following individual/organization is authorized to make the disclosure: _____
_____

2. The following individual/organization may receive disclosure of protected health information about me:
His/Her Organization Name & Address: _____
Phone #/Fax #: _____
_____
_____

3. The specific information that should be disclosed is (please give dates of service if possible):
_____

4. This information will be used as follows: _____
_____

No HIV/AIDS, Alcohol Abuse or Mental Health information will be released without special authorization.

5. I understand that the information disclosed may be subject to re-disclosure by the person of class or person of facility receiving it, and would then no longer be protected by federal privacy regulations.

6. I may revoke this authorization by notifying Chenango Memorial Hospital, Health Information Management Department in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the Medical Provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign authorization.

Unless I specify differently, this authorization will expire on: _____

7. If I fail to specify an expiration date this authorization will expire six months from the date on which it is signed.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
(Patient's Signature/The person about whom the information relates)	(Signature Date)	(Date of Birth)

OR if applicable-

_____	_____	_____
(Signature of Guardian or Personal Representative of Patient's Estate)	(Signature Date)	(Description of Authority to Act for the Individual)