



# Authorization for Disclosure of Patient Health Information

Eff. 10/2006  
Rev. 11/2018

<b>PATIENT NAME:</b>	<b>SOCIAL SECURITY NUMBER:</b>	<b>DATE OF BIRTH:</b>
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**Animas Surgical Hospital Medical Records Fax: 970-385-2389**

**Email Address: mr@animassurgical.com**

I authorize Animas Surgical Hospital the use or disclosure of my protected health information as described below. Animas Surgical Hospital is authorized to make disclosures to:  Patient  Other, individual or organization

<b>Name:</b>
<b>Address:</b>
<b>City/State:</b>
<b>Phone Number:</b> <b>Fax Number:</b>

PURPOSE OF THE RELEASE:  Continuity of Care  Legal  Personal  Other: \_\_\_\_\_

Date of Service(s) \_\_\_\_\_ to \_\_\_\_\_

*The extent or nature of information to be released:*

- Face Sheet
- Emergency Room Record
- Lab Results
- Imaging Reports
- Operative Report
- Pathology Report
- Entire Record
- EKG
- Other, please specify \_\_\_\_\_

Imaging PowerShare Enrollment **Email:** \_\_\_\_\_

**PATIENT ONLY:**

I request a copy of an accounting of the uses and disclosures of protected health information. The first accounting within a twelve (12) month period is free of charge, any additional request will be charged as listed above.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Services. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire ninety (90) days from the date of signing below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in section CFR 164.524 of the Health Insurance Portability and Accountability Act. I understand that if the person or entity authorized to receive the information is not a healthcare provider or health plan the released information may no longer be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Services

\_\_\_\_\_  
Signature of Patient or Legal Representative Date

\_\_\_\_\_  
If signed by Legal Representative, Relationship to Patient Date

\_\_\_\_\_ Date information released \_\_\_\_\_ Enrollment Date  
 \_\_\_\_\_ Initials of individual making disclosure \_\_\_\_\_ Initials of staff completing PowerShare enrollment