MOUNTAIN LAUREL MEDICAL CENTER

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Please Print Clearly

Patient Name: _____ **Date of Birth:** _____/_____/_____ **Today's Date:** _____/_____/_____
Last, First, MI

Patient Phone: _____

Authorization provided by: (circle one) Patient Parent Other Legal Guardian

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I HEREBY AUTHORIZE DISCLOSURE AND USE OF MY HEALTH INFORMATION TO THE FOLLOWING PEOPLE:

Name: (friends/ family only) **Phone** **Relationship to patient** **May Leave Message? (Y or N)**

1. _____
2. _____
3. _____

Mountain Laurel Medical Center may disclose the following protected health information: Place an "X" in the box

	Office Visit Notes		**Laboratory Tests/Results**		**Appointment Date/Time**		**Physical Exams**
	Diagnostics (x-ray, endoscopy, mammo, other)		**Immunization Records**		**Procedure Reports**		**Behavioral Health & Substance Abuse Records**
	Medications or Pharmacy Records		**Entire Medical Record (including behavioral health & substance abuse records)**		**Billing/Insurance Claims or Patient Statements**		**Newborn Summary**

List any information specifically ***excluded*** from disclosure: _____

Expiration of Authorization (1 year from date signed) _____/_____/_____

Patient Authorization – Please Read Carefully

I authorize the use and/or disclosure of my PHI as described above. I understand that I retain the right to revoke this Authorization at any time, if I do so in writing. My signature below indicates my understanding of my rights and that I'm allowing the release of the information that I have initialed above for disclosure. I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected and that Mountain Laurel Medical Center is hereby released from any legal responsibility or liability for such disclosure of to the extent indicated herein. I also understand that I have the right to inspect or copy my PHI to be used or disclosed pursuant to this Authorization, as permitted by law.

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Print Name of Parent or Legal Guardian Relationship to Patient

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For Internal Office Use Only
Authorization verified and recorded
By_____ On: _____