HOCKING VALLEY
Community Hospital

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Address: _____

MR#: _____ DOB: _____ SS#: _____

I authorize the use of disclosure of the above named individual's health information as described below.

The following organization is authorized to make the disclosure:

Hocking Valley Community Hospital
601 St Rt 664 N
PO Box 966
Logan OH 43138

Dates of service: _____

___ Discharge Summary	___ Physician's Orders	___ ED
___ History & Physical	___ Physical Therapy	___ Clinic
___ Progress Notes	___ MRI	___ X-Ray films
___ Labs	___ Consultations	___ X-Ray reports
___ Operative Report	___ Entire Record	___ Pathology Report

___ Disclosure Log

___ Other: (Please describe) _____

_____

_____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV.) It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to, and used by, the following:

Name: _____
Address: _____

This information is being disclosed for the following purpose(s): _____
_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to authorized Medical Record personnel at Hocking Valley Community Hospital. 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.

This authorization will expire on _____
If no date is indicated, authorization will expire ninety (90) days from the date signed.

I understand that once the information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal privacy regulations.

If you have questions about disclosure of your health information, contact the supervisor of the Medical Record Department at Hocking Valley Community Hospital.

You will be given a copy of this authorization form after signing.

If you wish for someone else to pick up your records, please indicate:

Name: _____ Relationship: _____

Signature of patient: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

If signed by Legal Representative, relationship to patient _____

Signature of Witness: _____ Date: _____

THERE IS A CHARGE FOR COPYING MEDICAL RECORDS FOR PERSONAL USE AND FOR ATTORNEYS.