AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH NFORAMATION

I hereby authorize: Saint Camillus Medical Center

To Release To: ____ Recipient Name

____ Street Address

____ City, State, Zip

Telephone #__________________ Fax# ___________________

The following information from the medical record of:
Patient Name_______________________________ Date of Birth_______________

Dates of Treatment ___________________________ Social Security No. _________

Information to be released:

__ Discharge Summary __ History & Physical __ Operative Report __ Path Reports
__ Laboratory Reports __ Consultation Report __ Medication Report __ EKG/ECHO
__ Progress Notes __ X-ray Reports __ Blood Type
__ Other____

The information specified above is to be released for the following purposes:
__ Treatment/Consultation __ Patient Request __Billing or Claims __Attorney
__ Social Security Disability __ Other (specify) ______________________________

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that if my medical or billing records contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, 1-lepatitis B or C testing, and/or oilier sensitive information, I agree to its release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address. This authorization will automatically expire 180 days from the date of my signature unless revoked prior to that tine or unless otherwise specified as follows

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative
I understand that Pine Creek Medical Center may not condition my treatment whether I sign this authorization form. I authorize Pine Creek Medical Center to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for record copies.

Signature of Patient or Legal Representative____
Date ____

Authority to sign if not Patient (documentation required) ____________________________________