



## AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ SSN: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**I hereby authorize Florence Hospital at Anthem, its directors, officers and employees to use or disclose the protected health information about the Patient identified above as described in this authorization.**

1. The following person (or class of persons) may receive disclosure of the patient's protected health information:

\_\_\_\_\_

Please choose from the following:

- Records to be picked up     Records to be mailed     Records to be released in a secure electronic format (excludes email)  
 Records to be faxed to a Care Provider; Please fill out the information below:

ATTN: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

2. The specific information that may be disclosed is (please give dates of service if possible):

Dates of Service: \_\_\_\_\_

- The most recent 6 months of pertinent information (ER chart, dictation, diagnostic imaging, labs, EKG)  
 All medical records     Other information (describe): \_\_\_\_\_

**EXCLUDE** the following information from the records release:

- HIV/AIDS information and other communicable diseases     Drug or alcohol abuse treatment information  
 Genetic testing information     Mental health treatment information

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by law.

4. I may revoke this authorization by notifying Florence Hospital's Privacy officer in writing of my desire to revoke it. Any exception to my right to revoke this authorization is included in Florence Hospital's Notice of Privacy Practices. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. I understand that my signature on this form is voluntary and that Florence Hospital will not condition treatment, payment, eligibility for benefits or enrollment on my decision to sign or not sign this form.

6. The purpose for which the disclosure is being made: \_\_\_\_\_

- Continued patient care     Personal use     Worker's compensation  
 Insurance coverage or payment     Attorney's office

7. This authorization expires on \_\_\_\_\_ If no date is indicated, this authorization will expire 90 days after the date of signature.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING**

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by someone other than the patient, state your relationship and your authority to act for the patient (if applicable)

\_\_\_\_\_  
Date

**Florence Hospital at Anthem**  
**Authorization for Release of Patient Health Information**

Page 1 of 1  
FH1001/022818

DOB :  
ADMIT :  
ADM :  
MR # :

AGE :  
RM/BED :  
PAT # :

HSV :  
SEX :  
# :

