THAYER COUNTY HEALTH SERVICES
Authorization for Use or Disclosure of Protected Health Information

_____ _____ _____

PATIENTS NAME **DOB** **PHONE NUMBER**

I AUTHORIZE: **RELEASE RECORDS TO:**

_____ _____

Name of Facility Name of Facility

_____ _____

Address/City/State Address/City/State

_____ _____

Phone/Fax Phone/Fax

DATES OF SERVICE: _____

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist.

Description of information that may be used/disclosed for dates (if applicable):

____Complete Medical Record ____Final Summary ____Dictated & signed Progress Notes
____H&P ____Radiology/Lab Results ____Other _____

The information will be used/disclosed for the following purposes:

____Insurance ____Judicial proceedings
____Moving/Transferring to another facility ____Other _____

The following item must be initialed to be included in the use and/or disclosure of other health information. Other rules may apply that prohibit the use/disclosure of PHI related to these conditions:

____HIV/AIDS related information and/or records _____Genetics testing information and/or records
____Psychotherapy Notes/Mental health information and/or records
____Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Describe:_____

I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements (42 CFR part2.)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance of this authorization. This authorization expires _____ **(insert applicable date or event) if no date specified, this will expire in 180 days.**

_____ _____

SIGNATURE OF PATIENT **DATE**

_____ _____

SIGNATURE OF REPRESENTATIVE **RELATIONSHIP TO PATIENT**

(A copy of this signed form will be available to the patient.)
(TCHS reserves the right to charge for copies of PHI.)