Community Rehabilitation Hospital

RELEASE OF INFORMATION AUTHORIZATION FORM

PATIENT NAME: _____ **DATE OF BIRTH** _____/_____/_____

SOCIAL SECURITY # _____-_____-_____ **TELEPHONE # Including Area Code (** _____ **)** _____-_____

FACILITY NAME: _____ **FACILITY #** _____

☐ **PATIENT REQUEST** ☐ **OTHER** _____

Purpose of Disclosure: ☐ Personal Use ☐ Legal Claim ☐ Insurance Claim ☐ Other: _____

PHI TO BE COPIED:

Medical information marked below covering: Start Date: _____ /_____ /_____ End Date: _____ /_____ /_____

☐ History & Physical ☐ Nursing Notes ☐ Emergency Records ☐ Consultation Reports

☐ Physician Orders ☐ MD Progress Notes ☐ Lab/X-Ray/Path. Results ☐ Other: _____

☐ Operative Results ☐ Discharge Summary ☐ Rehab Notes

Financial (Describe): _____ Start Date: _____ /_____ /_____ End Date: _____ /_____ /_____

Other (Describe): _____ Start Date: _____ /_____ /_____ End Date: _____ /_____ /_____

These records may include psychiatric, psychological, alcohol, substance abuse and/or HIV related records. Indicate any, which you **do not** authorize their release.

NAME & METHOD PHI IS TO BE RELEASED:

Name: _____

Street Address: _____ City _____ State _____ Zip _____

Method of Release: ☐ Fax #: _____ ☐ Mail ☐ Telephone ☐ Other

☐ E-Record (information is not encrypted and may not be secure) Email: _____

PATIENT'S AUTHORIZATION:

- I understand the potential for information disclosed under this authorization to be subject to re-disclosure by the recipient and may not be protected by HIPAA.
- I understand that authorizing the use and disclosure of this health information is voluntary and that I can refuse to sign this authorization. I need not sign this form in order to receive treatment reimbursement for services, enrollment in a health plan or eligibility for health benefits
- I understand that I may inspect a copy of the information to be used or disclosed.
- I understand that I can revoke this authorization in writing at any time and that the revocation will not apply to the extent that Kindred has taken action in reliance on this authorization.
- I authorize the use and disclosure of my health information as previously described. This authorization will expire once records requested above are released, unless otherwise extended or revoked in writing.

_____ _____ / _____ / _____

□ Patient / □ Legal Representative Printed Name /Signature Date

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STATUS OF REQUEST

□ Approved □ Denied: Reason for denial: _____

_____ _____ / _____ / _____

Privacy Contact (or Designee) Printed Name/Signature Date