



GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please complete the following information:

Patient Name: Address: Telephone Number: SSN: Date of Birth:

I authorize Providence Hospital: or other person/entity (specifically describe) to disclose/release the following information: (check all applicable) (Fees may be charged for processing this request.):

- Checkboxes for Inpatient Medical Records, Emergency Room, In and Out Surgery, Radiology Records, Laboratory/Pathology Records, Infusion Treatment Center, Other, Psychiatric Care Records, Pulmonary Rehab, Physical Rehab, Sleep Services, Physician Office Visits, Billing Records.

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s): Please send the records listed above to (use additional sheets if necessary): Name: Address: Phone: Fax:

The information may be used/disclosed for each of the following purposes: At my request (only patient can check this box), For my health care, For payment/insurance, For legal purposes, Other.

This authorization will expire in 60 days by DC law.

I understand that the records disclose my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

Signature of patient (or patient's personal representative)

Date

Printed name of patient representative and Relationship

Representative's authority to sign for patient, (i.e. parent, guardian, power of attorney for healthcare, executor)

A copy of this signed authorization must be given to the individual