

DEMOGRAPHICS

Patient Name: _____ **Address:** _____

Date of Birth: _____

Phone #: () _____

REQUEST INFORMATION

I hereby authorize _____ or its designee, to release the following specific information:

- Standard Packet*(see back of form)
- Radiology Report/Film
- Blood Type
- Emergency Room Records
- Lab Reports
- Entire Record
- Dates of Visit
- Other: _____

For the Approximate service dates of: _____

- For the purpose of:
- Personal Use
 - Insurance
 - Disability
 - Legal Purposes
 - Continuation of Care
 - Marketing (FHS will receive no remuneration)
 - Other

Information should be delivered via:

- Mail to address above
- Mail to: _____
- Inspection/Review Only
- Other _____ will pick up . (Arrangements to be made by HIM)
(name other than patient)
- Fax to: _____ at _____
(For Continuation of Care only) (Fax Number)

STATEMENTS OF UNDERSTANDING

- I authorize the release of information contained in my patient records, including alcohol and drug abuse protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, Behavioral Health, if any, HIV/AIDS related records, if any, and social services records, if any, including communications made by me to a social worker, to the individuals or organizations listed above, only under the conditions listed below.
- I understand that if a person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, excepting the instance of research related treatment or when the provision of healthcare to me is solely for the purpose of creating protected health information of disclosure to a third party.
- I understand that this consent is subject to revocation at anytime. I understand that if I revoke this authorization, I must do so in writing and obtain and file a revocation form with the HIM Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
- This authorization will expire in 60 days unless otherwise revoked. If this authorization is for a use or disclosure of PHI.
- Allegiance Health will strive to meet your health information needs, but does reserve the right to receive reasonable notice of request and reasonable time to complete request.

(Signature of Witness)

(Signature of Patient)

Date: _____

Date: _____

(Signature of Legal Representative)

If you are the authorized representative of the patient, describe the scope of your authority and attach necessary proof.

- Parent
- Legally Authorized Rep
- Personal Representative of Estate
- Durable Power of Attorney for Health Care
- Other: _____

***Standard Packet**

Discharge Summary - Report that summarizes your entire stay in the hospital. This includes your diagnosis, test results, hospital course, instructions after discharge and discharge planning.

History and Physical - Report that begins your hospitalization, stating your reason for admission, past medical history, your physical exam and plan for treatment.

Consultations - Reports that document the findings and recommendations of any consults performed by another physician.

Laboratory - These reports list all your lab tests performed and their results.

Radiology/X-rays - These reports show all radiology tests performed and their results.

Operative/Procedures - These reports detail your operation (if you had an operation while your were here) step by step showing your pre and post operative diagnosis.

Pathology Report - Shows pathologic diagnosis of any tissue removed from your body during a procedure.

EKG - Test that shows the electrical activity of your heart.

***Physician Practices / Urgent Care Standard Packet**

Office visit encounters, nurse notes, and provider notes regarding chief complaint, diagnosis, treatment plan and discharge information.

ID Verification:

- Drivers License **Initials:** _____
- Photo ID
- Other: _____
