Mason District Hospital

Medical Associates

Authorization to Disclose Health Information

Account Number_____

This authorization form must be completed in full. All required fields, including selection of location(s) of service, must be completed. Incomplete forms will be returned for correction.
I do hereby authorize Mason District Hospital and its affiliated clinics and service locations to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ (last four digits)
Covering the period(s) of healthcare from _____ to _____

Location(s) of Service (REQUIRED):

☐ Hospital
☐ Clinic

Clinic Location: _____

Information to be Disclosed:

☐ History and Physical
☐ Lab/Test Results
☐ Emergency Room
☐ Imaging Reports/Disc
☐ Operative Report
☐ Entire Record
☐ Office Visit
☐ Other (specify)

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services and treatment for alcohol and drug abuse. If contained in the health records, this information may be disclosed unless indicated by initialing on this line: _____ and selecting the information not to be disclosed.

DO NOT RELEASE THE FOLLOWING INFORMATION (Check those that apply):

☐ AIDS or HIV Information
☐ Sexually Transmitted Disease
☐ Behavioral or Mental Health
☐ Drug Alcohol Abuse

Please mark the preferred method of transmission and provide the necessary information:

☐ Waiting for Results
☐ Fax Number: _____
☐ Secure Email: _____
☐ U.S. Mail: (Address Below)

This information shall be disclosed to:

Name: _____

Phone: _____

Address: _____

_____

I understand this authorization may be revoked in writing at any time and submitted to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this or any other previously received authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand this authorization will expire, without my express revocation, ninety (90) days from the date of signing, or if I am a minor, on the date I become an adult according to state law.

I understand that once the above information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by federal policy laws or regulations.

I understand authorizing the use of disclosure of the information identified above is voluntary, I need not sign this form to ensure healthcare treatment.

If I have selected any method of transmission for health information listed on the first page, I acknowledge that Mason District Hospital cannot guarantee this information will not be intercepted by other parties. By using this form, I agree not to hold Mason District Hospital, affiliates or its employees responsible for any breach of confidentiality that may result from using methods of transmission to communicate with you or another person you may have designated to receive emails, faxes or U.S. mail that include your health information. I understand that reasonable means will be used to protect the security and confidentiality of the transmission.

By signing, I acknowledge that I have read, understand and agree with the above. By signing, I further understand that I may charge in accordance with state and federal statues for the processing of the required records.

Patient or Legal Representative Signature: _____ **Date:** _____

If signed by a legal representative, relationship to patient: _____

Signature of witness: _____ **Date:** _____

***Minors 12 years of age or older shall sign for release of their records pertaining to STDs, substance abuse, mental health and developmental diseases.**

You are entitled to a copy of this authorization once you sign it.

FOR OFFICE USE ONLY
(initial + date)

Processed by: _____

Pages: _____

Scanned in by: _____