Holly Hill Hospital

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email HOLLYHILL.MedicalRecords@uhsinc.com

Authorization to Use or Disclose Protected Health Information

_________________________________ ____________ _____________ __________________
(Patient/Resident Name) **(Date of Birth)** **(SS#)** **(Date(s) of Treatment)**

I hereby freely and voluntarily authorize Holly Hill Hospital to. . . .
_X_ Release/disclose my protected health information to:
___ Obtain my protected health information from:

____
(Individual, Facility, or Organization) **(Phone Number)**
____
(Address) **(Fax Number)**
____
(City, State, Zip Code)

The purpose of this disclosure is for:
__ insurance purposes **__ educational placement** **__ legal reasons** **__ medical treatment**
__ discharge planning **__ continued treatment** **__ the patient** **__ progress updates**
__ other (explain) ____

Information to be used or disclosed:
__ Discharge summary **__ Psychiatric Evaluation** **__ Medication records** **__ History & Physical**
__ Psychological testing **__ Lab/X-ray results** **__ Progress Report (verbal)**
__ Psychosocial assessment **__ Physician's Orders** **__ Comprehensive assessment**
__ Aftercare Plan **__ Medical consultations** **Other (explain) _________________________**

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Holly Hill Hospital's Privacy Officer, except to the extent that action has already been taken in reliance on it. **This authorization will expire 180 days ( ) following discharge, or(X) following signature** unless another date or condition is specified. Other date or condition specified: ___________________________________.

Signatures:

____ ____________
(Patient/Resident – When applicable by law or hospital policy) ***(Date)***

__________________________________ ______________ ___________________________________
(Guardian or Representative) ***(Date)*** ***(Relationship to Patient/Resident)***

__________________________________ ______________
(Witness) ***(Date)***

***Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

__________________________________ ___________________
Released by (Hospital staff) **Date**

DOCUMENTATION OF DISCLOSURES FOR AUTHORIZATION

Item(s) sent (check)	D/C Date(s)	Initials of staff	date sent
__ Discharge summary	____________	________	________
__ Psychiatric Evaluation	____________	________	________
__ Medication records	____________	________	________
__ History & Physical	____________	________	________
__ Psychological testing	____________	________	________
__ Lab/X-ray results	____________	________	________
__ Progress Report	____________	________	________
__ Psychosocial assessment	____________	________	________
__ Physician's Orders	____________	________	________
__ Comprehensive assessment	____________	________	________
__ Aftercare Plan	____________	________	________
__ Medical consultations	____________	________	________
__ Entire medical record	____________	________	________
Other (explain): ____________	____________	________	________

Released by (Staff signatures):

______________________ ________ ______________
Signature **Initials** **Date**

______________________ ________ ______________
Signature **Initials** **Date**

______________________ ________ ______________
Signature **Initials** **Date**