PROVIDENCE

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.):

- ☐ Inpatient Medical Records
- ☐ Emergency Room
- ☐ In and Out Surgery
- ☐ Radiology Records
- ☐ Laboratory/Pathology Records
- ☐ Infusion Treatment Center
- ☐ Pulmonary Rehab
- ☐ Physical Rehab
- ☐ Sleep Services
- ☐ Physician Office Visits
- ☐ Billing Records
- ☐ Other (describe specifically) ______________________________
- ☐ Psychiatric Care Records (**Note:** If this authorization is for psychotherapy notes, it may not be combined with any other authorization (other than another authorization for psychotherapy notes.)}

> *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: ______________________

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. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____
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