PATIENT NAME: _____ **Date of Birth:** mm dd yy

Social Security#: _____–_____–_____ **Telephone#** Including Area Code: (_____) _____–_____

FACILITY NAME: _____ **FACILITY#:** _____

☐ **PATIENT REQUEST** ☐ **OTHER** _____

Purpose of Disclosure: ☐ Personal Use ☐ Legal Claim ☐ Insurance Claim ☐ Other: _____

PHI TO BE COPIED:

Medical Information marked below covering: Start Date: _____/_____/_____ End Date: _____/_____/_____

☐ History & Physical	☐ Nursing Notes	☐ Emergency Records	☐ Consultation Reports
☐ Physician Orders	☐ MD Progress Notes	☐ Lab / X-Ray / Path Results	☐ Entire Chart
☐ Operative Reports	☐ Discharge Summary	☐ Rehab Notes	☐ Other: _____

Financial (Describe): _____ Start Date: _____/_____/_____ End Date: _____/_____/_____

Other (Describe): _____ Start Date: _____/_____/_____ End Date: _____/_____/_____

These records may include **reproductive health, psychiatric, psychological, alcohol, substance abuse** and/or **HIV** related records. Indicate any, which you **do not** authorize their release:

_____

NAME & ADDRESS PHI IS TO BE MAILED: (if not mailed, choose alternative method below)

Name: _____

_____

*Street Address *City *State *Zip Code

eMail Address: _____

OR BY: ☐ Email ☐ Pick Up ☐ Mail ☐ Fax ☐ Other _____

If information is being released by email - was the email encrypted? If not, document patient's request for email to be unencrypted or attach to this form. _____

Requesting Records by CD or Email: _____

PATIENT'S AUTHORIZATION:

- I understand the potential for information disclosed under this authorization to be subject to re-disclosure by the recipient and may not be protected by HIPAA.
- I understand that authorizing the use and disclosure of this health information is voluntary and that I can refuse to sign this authorization. I need not sign this form in order to receive treatment, reimbursement for services, enrollment in a health plan or eligibility for health benefits.
- I understand that I may inspect a copy of the information to be used or disclosed.
- I understand that I can revoke this authorization in writing at any time and that the revocation will not apply to the extent that Kindred has taken action in reliance on this authorization.
- I authorize the use and disclosure of my health information as previously described. This authorization will expire once records requested above are released, unless otherwise extended or revoked in writing.

_____ _____

☐ **Patient** / ☐ **Legal Representative Printed Name/Signature** **Date**

STATUS OF REQUEST:

☐ Approved ☐ Denied: Reason for denial: _____

_____ _____/_____/_____

Privacy Contact (or Designee) Printed Name/Signature **Date**

NOT A PERMANENT PART OF THE MEDICAL RECORD

Southwestern Medical Center
Empowered by ScionHealth

PATIENT IDENTIFICATION