Palisades Medical Center

HIPAA (Health Insurance Portability and Accountability Act)
AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I HEREBY AUTHORIZE ***PALISADES MEDICAL CENTER*** TO RELEASE TO:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

_____

Address (Street, City, State, Zip code) Phone Number

THE FOLLOWING INFORMATION FROM THE HOSPITAL RECORDS OF:

_____

Patient's Name Previous Names Birth Date Social Security #

INFORMATION TO BE RELEASED:
This authorization is limited to the following dates of treatment:

FROM _____ TO _____

☐ **COMPLETE RECORD – Please do not check additional boxes if complete record is requested**

☐ ABSTRACT (Includes: Discharge Summary, H&P, ER report, Consultations, Procedure reports and test results, as applicable.)

☐ EMERGENCY ROOM

☐ LAB, X-RAYS & TESTS

☐ OPERATIVE REPORTS & PATHOLOGY

☐ DISCHARGE SUMMARY

☐ CCD or SUMMARY OF CARE (electronic version) Only includes: Problem List, Medication List, Medication Allergies and Diagnostic Test Results

PATIENT INFORMATION IS NEEDED FOR:

___Personal Use ___Continuing Medical Care ___School ___Legal Purposes ___Social Security Disability ___Military

___Insurance ___Other _____

I understand that the specific information to be released may include, but is not limited to: history, diagnoses and/or treatment of drug or alcohol abuse, mental illness or communicable diseases including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). I authorize the release of these specific data. I understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information has been made prior to the receipt of the revocation. This authorization expires one year from the date of signature, unless I specify otherwise or revoke it. I understand that I may be charged for copies of my medical records.

I HAVE READ AND UNDERSTAND THIS CONSENT AND I HAVE SIGNED IT VOLUNTARILY AND OF MY OWN FREE WILL.

_____ _____

Signature of Patient Signature of Parent/Executor/Legal Representative

_____ _____

Date Relationship to Patient

_____

Date

Prohibition of Redisclosure: This information has been disclosed to you from records that are confidential. You are prohibited from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.