WINCHESTER MEDICAL CENTER
AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that any disclosure of information carries with it that potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

Patient Name (Last, First, MI):______________________________
Address:______________________________
Date of Birth:____________________ Social Security #:____________________
Medical Record Number:____________________

Extent of nature of use/disclosure is limited to: (Check or list all that apply)

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Medication List
- ☐ Allergy List
- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Physician Orders
- ☐ Treatment Plan
- ☐ Laboratory Results from (date)__________ to (date)__________
- ☐ X-Ray and Imaging Reports from (date)__________ to (date)__________
- ☐ Other:______________________________

I understand that the information in my health record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

To disclose information to:
Name, title and organization:______________________________
Address:______________________________
Phone/Fax:______________________________

Specified purpose or need for use/disclosure is:

- ☐ Diagnosis/Treatment
- ☐ Discharge Planning
- ☐ Other:______________________________

Unless otherwise revoked, this authorization will expire in:

- ☐ One Year
- ☐ On (specify date or event):______________________________

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this 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 that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact the Health Information Management Director at 536-8081.

______________________________ ______________________________
Signature of Patient or Legal Representative Date

______________________________ ______________________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness