

TRINITY MEDICAL CENTER
Steubenville, Ohio 43952

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby authorize _____ to disclose the following information from the health records of:

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

Social Security Number _____

Covering the period(s) of healthcare:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

2. Information to be disclosed:

- Complete Health Record(s)
- History & Physical Examination
- Progress Notes
- X-ray Reports
- Discharge Summary
- Consultation Reports
- Laboratory Tests
- Other (please specify) _____

Original X-ray Film - _____

Responsibility of Patient to return film within 30 days.

Copies of X-ray Film - _____

Patient does not need to return film.

I understand that this will include information relating to (check if applicable):

- Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)
- Psychiatric Care
- Treatment for Alcohol or Drug Abuse

3. This information is to be disclosed to the following:

Name _____ Telephone _____

Address _____

For the purpose of _____

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- 4. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 90 days from the date it is signed.
- 5. Trinity Health System, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- 6. Trinity Health System cannot require me to sign an authorization in order to receive treatment.
- 7. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.
- 8. Although applicable law may prohibit re-disclosure of these records, I understand that it is impossible to know if the facility/person that receives these records has re-disclose the information, therefore (1) Trinity Health System and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- 9. Incidental disclosure of sensitive information may be released without the patients specific authorization if this information is documented within the body of the record and is not the reason for visit.

Signed: _____
(Patient)

Date: _____

(or (Legal Representative)

Date: _____

(Relationship to Patient)

Signature of Witness: _____

WARNING: Report may or may not have been reviewed/signed at the time of release. Patient or other caregiver should verify any areas of concern with the treating physician prior to relying on report.