CRAIG | UNYIELDING DETERMINATION. EMPOWERING LIVES.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Legal Name _____ MR# _____

Address _____ City _____ State/Zip _____

Phone Number _____ E-Mail Address _____ Date of Birth _____

I hereby authorize: _____
Contact Person/Organization/Address

_____
Phone Number Fax Number

To disclose/release the Protected Health Information (PHI) of the patient listed above to:

_____
Contact Person/Organization

Address _____ City _____ State/Zip _____

Phone Number _____ Fax Number _____

Purpose: ☐ Continuation of Care ☐ Insurance or Workers Comp ☐ Litigation ☐ Other

PERTINENT PHI: *Dates of Treatment:* _____ *Specify Date Needed:* _____

- ☐ All Dictated Reports
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Team Conferences
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Psychology
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Radiology Images (Select One)
  - ○ Imaging Link via email to: _____
  - ○ USB
- ☐ Billing Records
- ☐ Entire Record
- ☐ Other: _____

ACKNOWLEDGEMENT: I request and authorize the above-named doctor or healthcare provider to release the information specified above to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding drug and alcohol abuse, communicable/infectious diseases, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and psychological or psychiatric conditions, if any. I understand that if the receiver is not a health plan or healthcare provider, the released information may no longer be protected by Federal Privacy regulations and may be redisclosed.

EXPIRATION: Without my express revocation, this authorization will automatically expire one year from the date hereof, unless otherwise specified:
_____

REVOCATION: I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. To revoke authorization, I must submit a letter to the Director of Health Information Management.

OTHER CONDITIONS: A copy or facsimile of this authorization with my signature may be used with the same effectiveness as an original. I understand that:

- If I do not sign this authorization, Craig Hospital will still provide treatment and seek payment for services provided.
- Fees/Charges will comply with all laws and regulations applicable to release of information.

I authorize _____ to pick up my Protected Health Information.

Date _____ Signature of Patient/Patient's Representative _____ Relationship to Patient _____

Witness _____ If patient is unable to sign, document reason _____

VERIFICATION: ☐ Power of Attorney ☐ Driver's license or other appropriate ID

ORIGINAL: Facility COPY: Patient or patient's representative following signature

#5008
Rev. 06/13, 03/17, 10/25