☐ I hereby authorize College Medical Center to furnish to (name and address of requester)

Name:_____ Address: _____

I am requesting that the records be handled in the following manner:

☐ Mail to the address listed above (shipping and handling will be charged separately)

☐ I will pick up

The requested information is for ☐ Patient ☐ Attorney ☐ Further Care ☐Other

This authorization is limited to the following medical records and types of information. Please **check** next to information you would like released for Date of Service of _____.

☐ Pertinent Information (Physicians' Documentations/ Diagnostic Reports)

☐ Emergency Room Record ☐ Behavioral Health Records, including Psychotherapy Notes

☐ Operative Report ☐ Alcohol or Drug Abuse

☐ Consultation Report/H&P ☐ Laboratory Results including HIV and Aids Records

☐ Discharge Summary ☐ X-Ray Film/ Reports ☐ Other (Specify): _____

- I understand H.I.M Department will inform me of any charges, and the payment for this service will be collected in advance (prior the records being copied). A photocopy or facsimile of this authorization shall be as good as the original.
- This authorization shall become effective immediately and will expire in six months from the requested date.
- I understand that College Medical Center takes no part in further use or disclosure of the records released in accordance to comply with this request.
- I understand that I have the right to revoke this authorization in writing.
- I understand that I have the right to receive a copy of this authorization upon request. Copy requested and received: ☐ Yes ☐ No
- With my signature below, I acknowledge that College Medical Center may provide me with an encrypted CD and a password to access my records. I understand the information on the CD is confidential and accept full responsibility to protect it from inappropriate access and to destroy the physical CD in accordance with HIPAA rules and regulations.

Phone number we may contact you at: ( ) __

_____ _____

Signature: *(Patient/Legal Representative)* Date/Time

_____

Print name: *(If signed by someone other than patient, indicate relationship)*

_____ _____ _____

Witness Signature Printed Name and Title Date/Time

COLLEGE MEDICAL CENTER

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

Name: _____

Date of Birth: _____