For Internal Use Only

DCH Health System®

Account #:_____
MR#:_____

Authorization to Disclose Protected Health Information

Patient's Full Name: _____
Date of Birth: _____ Social Security Number: _____
Date of Admission: _____ Date of Discharge: _____
Current Address: _____
Home Phone Number: _____ Work Number: _____

I authorize the release of information to be disclosed and used by the following:

TO: (Receiving Parties)

DCH Regional Medical Center
SpineCare
1050 Ruby Tyler Parkway
Tuscaloosa, Al 35404
Phone Number: (205) 759-7246
Fax Number: (205) 759-7348

Releasing Entity:

Any health plan, physician, health care professional, hospital Clinic, long term care facility, medical or medically related facility, or mental health facility, hospital or other medical practitioner or health care provider.

INFORMATION TO BE RELEASED: (Please check all that apply)

REPORT TYPES:

____Date of Admission and Discharge
____Final Diagnosis
____History & Physical
____Discharge Summary
____Consultation Report
____Other:_____

REPORT TYPES:

____Radiology Reports
____Operative Report
____Pathology Report
____Lab Report
____Emergency Room Report

Treating Facility (Check all that apply)

____Regional Medical Center **_____Northport Medical Center** **____Fayette Medical Center**

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug use.

Authorization to Disclose Protected Health Information:

The purpose for the use/disclosure of this information is:

_____Continued Medical Care
_____Patient/Personal Representative
_____Physician Care
_____Legal
_____Insurance
_____Other, specify:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in written revocation to the Health Information Management Medical Record Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this expiration date, event, or condition will expire on the following date, event, or condition: _____. If I fail to specify date, or condition, this authorization will expire in ninety (90) days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used, or disclosed, as provided in 45CFR 164.524. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Legal Representative, Relation to Patient **Signature of Witness**

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FOR INTERNAL USE ONLY

Identification of patient or Personal Representative:

____Driver's License
____Work Photo Badge
____Other Photo ID
____Social Security Number
____Notarized Signature
____Power of Attorney
____Executor Estate
____Administrator Estate
____Two Utility Bills

Reason why there is "NO CHARGE":_____