MonroeSurgical Hospital

AFFINITY HEALTH GROUP

Authorization for Release of Protected Health Information or to Obtain Protected Health Information (including paper, oral and electronic information)

Patient's Name: _____ Request Date: _____

Address: _____ (include City/State/Zip)

Date of Birth: _____/_____/_____ Last Four Digits of Social Security Number: XXX-XX-_____

Date of Service: _____/_____/_____ Name of Provider Who Ordered Treatment: _____

I Authorize:

Name: _____

Mailing Address: _____ (include City/State/Zip)

Relationship: _____ Telephone or Cell Phone Number: _____

_____ To Release Information To (information is being released)

_____ To Obtain Information From (information is being requested)

Name: _____

Mailing Address: _____ (include City/State/Zip)

Relationship: _____ Telephone or Cell Phone Number: _____

The Purpose of this Authorization is indicated below (place an "X" beside all that apply).

_____ Further Medical Care _____ Creating Health Information for Disclosure to Third Party

_____ Personal _____ Research Related Treatment _____ Quality improvement

_____ Changing Physicians/Providers _____ Legal Investigation or Action _____ Other: _____

I hereby authorize Monroe Surgical Hospital and/or Affinity Health Group to release the following protected health information to the above named individual or company (place an "X" beside all that apply).

_____ Entire Record _____ Prescriptions _____ Laboratory Reports _____ Immunizations

_____ Medical History, Examination, Reports _____ Consultation _____ Surgical Reports _____ X-Ray Reports

_____ Treatments or Tests _____ Discharge Summary _____ EKG, EEG

____ Hospital Records including Reports _____ Other: _____ DATE OF SERVICE_____

In compliance with state and or federal laws which require special permission to release otherwise privileged information, please indicate with a check whether the following records, if they exist, may be released:

_____ Alcoholism _____ Mental Health _____ Vocational Rehabilitation _____ Drugs _____ Genetics

_____ HIV(AIDS) _____ Sexually Transmitted Diseases _____ Psychotherapy Notes _____ Other: _____

This authorization shall be considered effective as of the date signed below. Date or Event on which this authorization will expire: _____ If not specified, I understand this authorization will expire twelve (12) months from the date of authorization.

_____ _____

Signature of Individual or Personal Representative Authorized by Law **Date**

MSH Use Only
DL# _____

Employee Initials _____

Release Date ___/___/____