FLORENCE HOSPITAL at ANTHEM

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient's Full Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City, State, Zip Code: _____ Phone: _____

I hereby authorize Florence Hospital at Anthem, its directors, officers and employees to use or disclose the protected health information about the Patient identified above as described in this authorization.

1. The following person (or class of persons) may receive disclosure of the patient's protected health information:

   _____

   Please choose from the following:
   ☐ Records to be picked up ☐ Records to be mailed ☐ Records to be released in a secure electronic format (excludes email)
   ☐ Records to be faxed to a Care Provider; Please fill out the information below:

   ATTN: _____ Phone #: _____ Fax #: _____

2. The specific information that may be disclosed is (please give dates of service if possible):

   Dates of Service: _____

   ☐ The most recent 6 months of pertinent information (ER chart, dictation, diagnostic imaging, labs, EKG)

   ☐ All medical records ☐ Other information (describe): _____

   EXCLUDE the following information from the records release:
   ☐ HIV/AIDS information and other communicable diseases ☐ Drug or alcohol abuse treatment information
   ☐ Genetic testing information ☐ Mental health treatment information

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by law.

4. I may revoke this authorization by notifying Florence Hospital's Privacy officer in writing of my desire to revoke it. Any exception to my right to revoke this authorization is included in Florence Hospital's Notice of Privacy Practices. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. I understand that my signature on this form is voluntary and that Florence Hospital will not condition treatment, payment, eligibility for benefits or enrollment on my decision to sign or not sign this form.

6. The purpose for which the disclosure is being made: _____
   ☐ Continued patient care ☐ Personal use ☐ Worker's compensation
   ☐ Insurance coverage or payment ☐ Attorney's office

7. This authorization expires on _____. If no date is indicated, this authorization will expire 90 days after the date of signature.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
If signed by someone other than the patient, state your relationship and your authority to act for the patient (if applicable) Date

DOB: AGE: HSV:
ADMIT: RM/BED: SEX:
ADM: /
MR #: #:
PAT #: