MEMORIAL HOSPITAL of CONVERSE COUNTY
Advanced Medicine. Hometown Care.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

SUMMIT MEDICAL CENTER
Elevating the Standards of HealthCare.

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____ Daytime Telephone: _____

Information To Be Released From:

☐ Memorial Hospital of Converse County & Clinics ☐ Summit Medical Center

Other Provider Name/Organization: _____Address:_____

Release Information To: (please be specific) Person/Organization: _____ Address: _____

Phone Number: _____ Fax Number: _____ Reason for Release:_____ (must complete)

Dates of Service: _____

Information to be Disclosed:

☐ Pertinent Summary Reports (Discharge, Operative, ER, X-Ray, Lab, etc.) ☐ Entire Record ☐ Physician Office Notes ☐ Billing Information ☐ Other (Specify):

Disclosure Requiring Special Consent:

By initialing, I specifically authorize the release of the following confidential information:

☐ Treatment Recommendations _____ ☐ Prognosis_____ ☐ Program Compliance _____
☐ Discharge Summary/Status Report_____ ☐ Treatment Plan_____ ☐ Medication Assisted Compliance_____
☐ Medication Compliance_____ ☐ Psychological/Psychiatric Reports_____ ☐ Urinalysis Results_____
☐ Substance Abuse Assessment_____ ☐ Medication Assisted Treatment_____ ☐ Diagnosis_____
☐ HIV Test Result & Related information _____ ☐ Acknowledge Presence in Treatment/Attendance_____ ☐ Other_____

Notice: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2), which provides additional protection to substance abuse, mental health, and other behavioral health records. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute any patient with a substance use disorder, except as provided under the regulations. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the 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, the authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, this authorization will expire in twelve months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of health information, I can contact the Health Information Management department at MHCC.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness Date

Patient Information Label

For Facility Use Date Received:_____ Date Information Released_____

Person/Department Sending Records: _____