SOUTHWEST HEALTH SYSTEM

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

| | |
|---|---|
| Patient Name:<br>Address: | Phone Number: _____<br>Date of Birth: _____<br>Last 4 digits SSN#: _____ (optional) |

**I, _____, hereby authorize disclosure of my protected health information as follows:**

**RELEASE FROM:**

| | |
|---|---|
| Facility, Person, Provider:<br>Address: | Phone Number: _____<br>Fax Number: _____*<br>E-mail: _____<br>(e-mailed information will be encrypted) |

**RELEASE TO:**

| | |
|---|---|
| Facility, Person, Provider:<br>Address: | Phone Number: _____<br>Fax Number: _____*<br>E-mail: _____<br>(e-mailed information will be encrypted) |

***SHS DOES NOT FAX PERSONAL HEALTH INFORMATION TO HOME FAX MACHINES**

**Information to be released:** From (date) _____ to (date) _____

- ☐ Treatment Records-Hospital
- ☐ Office Visit Notes - Clinic
- ☐ Consultation Reports
- ☐ Other, list below:
- ☐ Laboratory Reports
- ☐ Diagnostic Imaging Reports
- ☐ Operative Reports
- ☐ Emergency Room Records
- ☐ Discharge Summary
- ☐ Ambulance Run Reports
- ☐ History and Physical
- ☐ Pathology Reports
- ☐ Sleep Lab Reports

_____.

**Purpose of Release:** ☐ Medical Care ☐ Transferring Care ☐ Attorney ☐ Personal Records ☐ Other: _____.

**Sensitive Information:** I understand by checking any boxes below, I have given permission to release confidential information related to HIV, Mental Health Care, or Drug and Alcohol Treatment, which is protected by federal law 42 CFR Part 2. (If the boxes are not checked, this information will **NOT** be released.)

- ☐ Diagnosis and/or treatment relating to drug or alcohol abuse
- ☐ Diagnosis and/or treatment relating to mental health conditions
- ☐ Diagnosis and/or treatment relating to HIV testing, infection or diagnosis and/or treatment for AIDS

**Right to Revoke**: I understand that I may revoke this Authorization at any time by notifying Southwest Health System, Inc., in writing. I understand that revocation will not have any effect on actions taken prior to receipt of the revocation.

**Expiration:** This Authorization will automatically expire 180 days from the date of my signature, unless otherwise specified as follows: _____(date).

**Re-Disclosure:** I understand that the information used and/or disclosed according to this Authorization may no longer be protected by federal privacy law also known as HIPAA, and the recipient of the health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

**With my signature below, I acknowledge and authorize Southwest Health System, Inc., to use and/or disclose my protected health information as described above. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.**

Patient name printed: _____ Date of Signature: _____/Time:_____

Patient signature: _____

Patient representative name printed: _____

Patient representative signature: _____/ Relationship to Patient: _____