



RELEASE OF PROTECTED HEALTH INFORMATION AND DISCLOSURE AUTHORIZATION

Having been fully informed of the circumstances in connection with the request for information from my clinical record, I hereby authorize & request Touchette Regional to release and disclose the following protected health information:

PATIENT NAME: _____ DATE OF BIRTH: _____

Verbal Release (Last, first, initial) (MM/DD/YYYY) Patient to sign (Circle One) (Unresponsive)

Release to: Name: _____ I consent to my photo being Taken for release of records.

Address: _____

Phone/Fax Number: _____

Obtain from: Name: _____

Address: _____

Phone/Fax Number: _____

DISCLOSURES: Hospitalization

Dates: _____

Purpose of disclosure :(Check One)

Insurance Claim Medical Personal Legal Counsel Investigative Disability Other: (Please Specify)

I specifically request the release and disclosure of the following protected health information:

- Face Sheet Newborn Data Sheet Consultation Discharge Summary Surgical/Delivery Report History/Physical Physician's Orders/Notes Laboratory/Pathology Report Physical Therapy Ultrasound/Sonogram/X-ray/Scans (CAT, Brain, Lung etc) and/or films EKG/Echo Reports/Stress Test/24-Hour Holter Monitor Respiratory (Pulmonary) Therapy Emergency Room Nurses' Notes Complete Records Other :(Please Specify)

DISCLOSURES REQUIRING SPECIAL AUTHORIZATION PLEASE INITIAL:

Alcohol/Drug Abuses, Sexually transmitted diseases/HIV results, and any psychological assessments

ATTENTION: Once the above information has been released pursuant to this Authorization it may not longer be protected by Federal and/or State law or regulations; and may no longer be deemed "CONFIDENTIAL".

Signature below acknowledges that I understand:

- I may revoke this authorization in writing at any time with the exception to the extent that action has been taken on this authorization. I further understand that this authorization shall expire without my express revocation, ninety (90) days from the above date. I understand that I am voluntarily signing this authorization, that I have the right to refuse to sign this authorization and that the information that is released will no longer be protected under the federal privacy laws. I have a right to request a copy of this authorization, inspect or obtain a copy of the information to be disclosed and that Touchette Regional Hospital may assess reasonable fee that comply with the federal and state laws.

SIGNATURES: I agree to the above information and authorize Touchette Regional Hospital to disclose the above information to the designated individuals.

Patient/Legal Guardian Signature: _____ Date _____

If authorizing signature is not that of patient indicate legal relationship to patient:

Witness: _____ Name: _____

Date _____

Medical Record Use Only: TRH Correspondence Employee, _____
(618-332-5423)

Number of Pages: _____ Charges _____ Amount Paid _____ Date
Sent _____

Physician(s) ' _____ name(s) : _____

Please forward completed authorization or correspondence to TRH Health Information Dept at the address above.
HI#001

07/10