



## Authorization For Disclosure of Health Information

I hereby authorize \_\_\_\_\_ To release the following health information to Carteret General Hospital.

I hereby authorize Carteret General Hospital to disclose the following information from the health records of:

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone \_\_\_\_\_ Pt # / MR # \_\_\_\_\_

### Covering the period(s) of healthcare:

From (Date) \_\_\_\_\_ To (Date) \_\_\_\_\_

### Information to be disclosed:

- \_\_\_\_\_ Complete health record(s)
- \_\_\_\_\_ Discharge Summary
- \_\_\_\_\_ History & Physical Examination
- \_\_\_\_\_ Consultation Reports
- \_\_\_\_\_ Photographs, videotapes, digital or other images
- \_\_\_\_\_ Other, please specify \_\_\_\_\_
- \_\_\_\_\_ Progress Notes
- \_\_\_\_\_ Laboratory Tests
- \_\_\_\_\_ X-ray Reports and/or CDs

I also understand this release will include information relating to

- 1) Specific diagnoses such as AIDS (acquired immunodeficiency syndrome, HIV (human immunodeficiency virus) infection, MRSA, VRE;
- 2) Psychiatric care; and
- 3) Treatment for alcohol and/or drug abuse.

I do not wish the following information to be released: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Disclose the information** as listed above to \_\_\_\_\_  
for the purpose of \_\_\_\_\_

**Information disclosed may be subject to Rediscovery by the Recipient and is no longer protected by the Privacy Rule.**

**Revocation** – I understand this authorization may be revoked at any time by providing a written statement to the Director of the Medical Records Department at Carteret General Hospital except to the extent that action has been taken in reliance on this authorization. This authorization will expire 90 days from date of authorization unless otherwise noted.

I wish this authorization to expire on (date) \_\_\_\_\_ . \_\_\_\_\_ Patient Initial

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative's relationship to patient

\_\_\_\_\_  
Signature of Witness

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M. AUTHDISC