Monroe Surgical Hospital

AFFINITY HEALTH GROUP

Authorization for Release of Protected Health Information or to Obtain Protected Health Information (including paper, oral and electronic information)

Patient's Name: ______________________ Request Date: __________

Address: ______________________ (include City/State/Zip)

Date of Birth: ____/____/____ Last Four Digits of Social Security Number: XXX-XX-________

Date of Service: ____/____/____ Name of Provider Who Ordered Treatment: ______________________

I Authorize:

Name: ______________________

Mailing Address: ______________________ (include City/State/Zip)

Relationship: ______________________ Telephone or Cell Phone Number: ______________________

________ To Release Information To (information is being released)

________ To Obtain Information From (information is being requested)

Name: ______________________

Mailing Address: ______________________ (include City/State/Zip)

Relationship: ______________________ Telephone or Cell Phone Number: ______________________

The Purpose of this Authorization is indicated below (place an "X" beside all that apply).

____ Further Medical Care ____ Creating Health Information for Disclosure to Third Party

____ Personal ____ Research Related Treatment ____ Quality improvement

____ Changing Physicians/Providers ____ Legal Investigation or Action ____ Other: __________

I hereby authorize Monroe Surgical Hospital and/or Affinity Health Group to release the following protected health information to the above named individual or company (place an "X" beside all that apply).

____ Entire Record ____ Prescriptions ____ Laboratory Reports ____ Immunizations

____ Medical History, Examination, Reports ____ Consultation ____ Surgical Reports ____ X-Ray Reports

____ Treatments or Tests ____ Discharge Summary ____ EKG, EEG

____ Hospital Records including Reports ____ Other: __________ DATE OF SERVICE__________

In compliance with state and or federal laws which require special permission to release otherwise privileged information, please indicate with a check whether the following records, if they exist, may be released:

____ Alcoholism ____ Mental Health ____ Vocational Rehabilitation ____ Drugs ____ Genetics

____ HIV(AIDS) ____ Sexually Transmitted Diseases ____ Psychotherapy Notes ____ Other: __________

This authorization shall be considered effective as of the date signed below. Date or Event on which this authorization will expire: __________ If not specified, I understand this authorization will expire twelve (12) months from the date of authorization.

______________________ __________

Signature of Individual or Personal Representative Authorized by Law Date

MSH Use Only
DL# __________

Initials ______ Date ___/___/___

Provider/Clinic for Disc: