Cabell Huntington Hospital

HOOPS FAMILY Children's HOSPITAL AT CABELL HUNTINGTON HOSPITAL

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Name: _____DOB_____ SS#_____

Address _____

_____

SEND INFORMATION TO: (please be specific) _____Call to pick up

Name/Organization _____ _____Daytime phone

Address: _____

_____

PURPOSE OF USE/DISCLOSURE: ☐ Further medical treatment ☐ personal use* ☐ Other**(Specify)_____
*A charge of .75 per page may apply. **.75/page and $10 retrieval fee may apply.

TYPE OF TREATMENT YOU RECEIVED: (include dates if possible)

	Date(s) of Service
☐ Inpatient	_____
☐ Emergency Room	_____
☐ Outpatient Surgery	_____
☐ Other: (please specify)	_____

SPECIFIC INFORMATION TO BE USED/DISCLOSED:

☐ Entire Record ☐ Discharge Summary ☐ History & Physical ☐ Consultation
☐ Operative/Pathology Report ☐ X-ray ☐ Lab ☐ Other (specify)_____

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

☐ HIV/AIDS Virus _____
signature

☐ Drug, Alcohol Abuse/Treatment _____
signature

☐ Protected Health Information on a minor _____
signature of minor

I authorize the use or disclosure of health information as specified above. I understand that authorizing the use or disclosure of this health information is voluntary and treatment, payment or other benefits may/may not be conditioned on the execution of the authorization. **I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards.**

I understand that I have a right to revoke this authorization at any time, providing the information has not already been used or disclosed. I understand I must do so in writing and present it to the Health Information Management Department at Cabell Huntington Hospital.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

_____ _____ _____
Signature of patient or Legal Representative Date Witness
Attach copy of legal documentation (i.e. POA, Executor)

CHH- 748 Revised 4/2/03, 7/14/10,7/20/11, 6/3/13
ORIGINAL: HOSPITAL
COPY REQUESTOR