

**AUTHORIZATION TO RELEASE INFORMATION TO/FROM RHASA**

**Patient's Name:** \_\_\_\_\_  
**Patient's Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Social Security #:** \_\_\_\_\_

I authorize the release of information TO/FROM RHASA from the entity listed below:

**Name of Physician, Institution, Self, etc.** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**City/State/Zip** \_\_\_\_\_  
**Phone Number** \_\_\_\_\_  
**Fax Number** \_\_\_\_\_

Dates of treatment (which dates of treatment do you need records for?) \_\_\_\_\_  
The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

**Information to be released:**  
 Discharge Summary  
 History & Physical  
 Operative Report  
 X-Ray  
 Labs  
 Clinic Visits

ER Records  
 HIV Results \_\_\_\_\_ (initials)  
 Mental Health Records \_\_\_\_\_ (initials)  
 EKG  
 Physician Orders  
 Other: \_\_\_\_\_

**Purpose of release:**  
 Attorney  
 Social Security  
 Continuation of Care  
 Worker's Comp  
 Billing  
 Disability  
 Insurance  
 Disposition  
 Other: \_\_\_\_\_

Expiration date for expressed authorization is \_\_\_\_\_. If the patient does not express a desire for a specific date or condition to revoke his/her authorization will expire ninety (90) days from the date signed by the patient or patient's legal representative. I have read, or have had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or patient's legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exist, as detailed by federal law, such as:  
• RHASA has taken action in reliance on the authorization, or  
• The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a claim under the policy.  
In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the Privacy Officer of RHASA. This revocation document must contain the signature of the patient or patient's legal representative, and that signature must be formally certified by a Notary Public. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

**Signature of Patient or Patient's Legal Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(If a personal representative of the individual signs the authorization, a description of such representative's authority to act on behalf of the individual must be provided.)

Relationship, if not the patient \_\_\_\_\_

Photo ID was Provided  Yes  No

Date: \_\_\_\_\_

Witness \_\_\_\_\_