Grand Valley Oncology Community HOSPITAL

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Revision Date 10/28/19

Health Record # _____

Patient Name: _____

Address: _____

Date of Birth: _____ Telephone #: _____

RELEASE FROM: Grand Valley Oncology PHONE: 970-644-3180 FAX: 970-644-3198

RELEASE TO: **NAME** **RELATIONSHIP** **PHONE NUMBER**

_____

_____

_____

_____

METHOD OF RELEASE: ☐ **In Person** ☐ **By Phone** ☐ **FAX**

I authorize the use or disclosure of the above-named individual's health information, as described below.
The following information is to be disclosed. (Please check)

☐ Radiology (X-Ray, CT scan, MRI scan, US) reports ☐ Laboratory tests ☐ Physician consultation
☐ History and physical examinations ☐ Discharge summary
☐ ALL INFORMATION RELATED TO MY TREATMENT AND CARE

Sensitive Information: I understand that the above-mentioned records may include information relating to (check to authorize release):

☐ Acquired immune deficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
☐ Med/Psych rehabilitation ☐ Sexually transmitted disease(s)
☐ Diagnosis/treatment for alcohol and/or drug use ☐ Information for research purposes

Purpose of this request: ☐ Continued care ☐ Personal use ☐ Other (specify):_____

Disclosure: I understand that any disclosure of medical information carries with it the potential for re-disclosure, and that the recipient may not be governed by the federal privacy and confidentiality legislation.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization I must do so in writing and present my written revocation to the Director of Health Record Information Services or the Compliance Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Expiration: This authorization will expire on the following date:_____
☐ This release is valid until or unless I revoke it in writing.
If I do not specify an expiration date or revoke in writing, I understand this authorization will expire upon release of the information requested, or 120 days from the date of signing.

1. If I have questions about disclosure of my health information, I can contact the Compliance Officer (970-644-3015) or the Director of Health Record Information Services (970-644-3391).
2. I understand that I may request a copy of this authorization form, after signing. I understand that I need not sign this form in order to receive healthcare treatment.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ Date:_____

If signed by Legal Representative, relationship to Patient: _____ Date:_____

Signature of Witness (not required): _____ Date:_____