HEALTH INFORMATION MANAGEMENT
AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Springhill Medical Services, Inc Medical Record#_____ Date Requested _____

Patient Name_____Date of Birth:_____

Address_____PH#_____

I authorize _____to release my protected health information from my medical record to:

Name: _____

Address:_____ PH#_____

Purpose of authorization: ☐Personal ☐Legal ☐Insurance ☐ Continuing Medical Care ☐Other_____

Information to be released is for date of service from _____to_____.

Information to be released includes:

☐ Complete Medical Record	☐ X-ray reports	
☐ Discharge Summary	☐ Medication information	☐ X-ray films
☐ History & Physical	☐ Physicians Orders	☐ Lab & Path
☐ Progress Notes	☐ Operative Note	☐ Echo
☐ Consultation Note	☐ Nursing Information	☐ ER Record

☐Other:_____

For the purpose of review/examination, I further authorize/ consent to the release of information which may contain sensitive material related to (check all that apply): ☐ Substance Abuse ☐Genetics ☐HIV/ AIDS ☐Psychiatric/Mental Health. _____ (initial). If not applicable check here ☐.

Please provide in: ☐Paper or ☐Electronic Format

This authorization will automatically expire one year from the date signed.

I further understand that:

I may refuse to sign this authorization and that my refusal will have no impact on receiving treatment.
I may revoke this consent at any time in writing, except to the extent that action has been taken thereon.
The information released may not be covered by the federal privacy laws and may be redisclosed.

_____ _____
Patients Signature Date

_____ _____
Legal Representative (state authority/relationship) Date

_____ _____
HIM/hospital representative Date

P.O. Box 920 Springhill, LA PH: 539-1015 Fax: 539-3907