AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION



Patient Name: Date of Birth: / / Social Security No.: I hereby authorize Brooks Health System to release/receive my confidential health information to/from: Recipient's Name/Facility: Recipient's Phone: Recipient's Fax: Address: City: State: Zip: Email Address (Use ALL CAPS) : State: Zip: Purpose of Disclosure: Copies of Record Provided) Fax (Physician Only) Fax (Physician Only) Legal Reason Discussion of Record Biscussion of Record Fax (Physician Only) Fax (Physician Only) Other (Specify) Discussion of Record Batteriot Only/Abstract Only) Easily and the copy of Copy Section B: Description of Information to be used or discussed Description: Date(s) of Service: Location Commission Consultation Reports Medications Biling Records Biling Records Boroks Rehab I history & Physical Unical Tests Diagnosis Batterner Copy Boroks Rehab Progress Notes Evaluations/ Other: Outpatient Rehab Biling Records Biroks Rehab Biling Records Discussion of any withing Notes Biling Records Biroks Rehab Biroks Rehab	Section A: (This section n	nust be complete to be valid	l)				
Recipient's Name/Facility: Recipient's Phone: Recipient's Fax: Address: City: State: Zip: Address: City: State: Zip: Email Address (Use ALL CAPS) : Copies of Record Delivery Method: (If left blank, a paper copy will be provided) Copies of Record Delivery Method: (If left blank, a paper copy will be provided) Insurance Purposes Copies of Record Delivery Method: (If left blank, a paper copy will be provided) Fax (Physician Only) Other (Specify) Description Preview of Record Description: Delivery Method: (If left blank, a paper copy will be provided) Section B: Description of Information to be used or disclosed Description: Date(s) of Location Service: Bartram Crossing Admission Consultation Reports Medications Brooks Rehab Hospital Physicial orders Clinical Tests Billing Records Books Home He Brooks Home He Physical conders Clinical Tests Billing Records Other: Outriversity Crossis I acknowledge, and hereby consent to such, that the released information may contain HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions. Imitiats I moderestad	Patient Name:				Social S	Security No.	:
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Admission Consultation Reports Medications Bartram Crossing Documentation Therapy Notes Transfer forms Brooks Rehab History & Physical Nursing Notes Diagnosis Brooks Rehab Physician orders Clinical Tests Billing Records Brooks Medical C Discharge Summary Assessments Other: Doubter: Outpatient Rehab I acknowledge, and hereby consent to such, that the released information may contain HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions. (Initials) I understand that: Information used or disclosed pursuant to this authorization. Information used or disclosed pursuant to this authorization. Information used or disclosed pursuant to this authorizations. Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorization Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorization Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorization Patient information provided on a USB flash drive is for patient requests only and requires decryption with a prov password.	Section B: Description of	Information to be used or o	disclosed				
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AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION

Signature of Patient/Guardian/Patient Representative:	Date:	Signature of Witness:	
Print Name of Patient/Guardian/Patient Representative:	Relationship to Patient:		

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Medical Record # Account #