Medical Record # **Account #**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

BROOKS Rehabilitation

Section A: (This section must be complete to be valid)

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) :

Purpose of Disclosure:	**Type of Access:**	**Delivery Method:** **(If left blank, a paper copy will be provided)**
☐ Continuation of Care ☐ Insurance Purposes ☐ Legal Reason ☐ Personal Use ☐ Other (Specify) _____	☐ Copies of Record ☐ Review of Record ☐ Discussion of Record	☐ Fax (Physician Only) ☐ Mailed – Paper Copy ☐ Pick Up – Paper Copy ☐ Email (Patient Only/Abstract Only) ☐ Encrypted ☐Unencrypted ☐ USB Flash Drive (Patient Only)

Section B: Description of Information to be used or disclosed

Description:	**Description:**	**Description:**	**Date(s) of Service:**	**Location**
☐ Admission Documentation ☐ History & Physical ☐ Physician orders ☐ Progress Notes ☐ Discharge Summary	☐ Consultation Reports ☐ Therapy Notes ☐ Nursing Notes ☐ Clinical Tests ☐ Evaluations/ Assessments	☐ Medications ☐ Transfer forms ☐ Diagnosis ☐ Billing Records ☐ **Other:** _____		☐ Bartram Crossing ☐ Brooks Rehab Hospital ☐ Brooks Home Health ☐ Brooks Medical Group ☐ Outpatient Rehab ☐ University Crossing

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:

1. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
2. I may revoke this authorization at any time in writing. I understand the revocation will not apply to information already released in response to this authorization.
3. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by state or federal privacy regulations.
4. Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorization.
5. Upon request, I may receive a copy of this form after I sign it.
6. If I fail to specify expiration date or condition as set forth below, this authorization is valid for 6 months from the signature date.
7. Patient information provided on a USB flash drive is for patient requests only and requires decryption with a provided password.
8. I understand there are risks for obtaining my records through unencrypted email and accept responsibility for those risks. Risks include, but are not limited to, interception of email by a third party, read or accessed by unintended recipient, or sent to the wrong recipient.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

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Signature of Patient/Guardian/Patient Representative:	**Date:**	**Signature of Witness:**
Print Name of Patient/Guardian/Patient Representative:	**Relationship to Patient:**	
Authorization **expires 6 months from the date signed** unless otherwise specified below: **Expiration Date/Event:**		

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OF PROTECTED HEALTH INFORMATION

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