## 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.	:
Address:       City:       State:       Zip:         Address:       City:       State:       Zip:         Email Address (Use ALL CAPS) :       Copies of Record       Purpose of Disclosure:       Copies of Record       Description of Care       Purpose of Record       Purpose of Record       Paper Copy         Insurance Purposes       Discussion of Record       Paper Copy       Paper Copy       Paper Copy       Provided)       Image: Copies of Record       Paper Copy       <	I hereby authorize Brooks	s Health System to release/r	eceive my	confidential hea	lth inforn	nation to/fro	)m:
Email Address (Use ALL CAPS) :         Purpose of Disclosure: Continuation of Care Insurance Purposes       Type of Access: Costinuation of Care Review of Record Discussion of Information to be used or disclosed Description:       Delivery Method: (If left blank, a paper copy will be provided) Discussion Oly Discussion of Record Discussion of Record Discussion Documentation Discussion Documentation Discharge Summary       Description: Description: Description: Discharge Summary Assessments       Description: Discharge Summary Discussion Discharge Summary       Description: Discharge Summary Discussion Discharge Summary Discussion Discharge Summary       Description: Discharge Summary Discussion Discharge Summary       Description: Discharge Summary Discussion Discharge Summary Discussion Discharge Summary       Description: Discharge Summary Discharge Summary       Discharge Summary Discharge Summary Discharge Summary Discharge Summary Discharge Summary       Discharge Summary Discharge Summary Discharge Summary Discharge Summary       Discharge Summary Discharge Summary Discharge Summary Discharge Summary Discharge Summary       Discharge Summary Discharge Discha	Recipient's Name/Facility	:	Reci	<mark>pient's Phone:</mark>		Recipient'	<mark>s Fax:</mark>
Purpose of Disclosure:       Type of Access:       Delivery Method;       (If left blank, a paper copy will be provided)         □ continuation of Care       □ Review of Record       □ Fax (Physician Only)       □ Fax (Physician Only)         □ Legal Reason       □ Discussion of Record       □ Fax (Physician Only)       □ Fax (Physician Only)         □ Other (Specify)       □ Discussion of Record       □ Encrypted □Unencrypted       □Unencrypted         □ Other (Specify)       □ Encrypted □Unencrypted       □Unencrypted       □Userview of Record         □ Admission       □ Consultation Reports       □ Description:       Description:       Date(s) of Service:         □ Admission       □ Consultation Reports       □ Medications       □ Bartram Crossing         □ History & Physical       □ Nursing Notes       □ Billing Records       □ Brooks Home Hee         □ Progress Notes       □ Clnical Tests       □ Billing Records       □ Brooks Home Hee         □ bischarge Summary       Assessments       □ Other:       □ Outpatient Rehab         1 Advisoin order state or dotations, alcohol abuse, drug abuse, psychological or psychiatric conditions.       □ Diversity Crossit         □ bischarge Summary       Assessments       □ Interstand the revocation will not apply to information already released in response to this authorization any time in writing. I understand the revocation will not apply to information ala	Address:		City:		State:		Zip:
□ Continuation of Care       □ Copies of Record       □ Fax (Physician Only)         □ Legal Reason       □ Discussion of Record       □ Fax (Physician Only)         □ Personal Use       □ Discussion of Record       □ Pick Up – Paper Copy         □ Other (Specify)       □ Discussion of Record       □ Encrypted □ Unencrypted         □ Bescription       □ Information to be used or disclosed         Description:       Description:       Detection         □ Admission       □ Consultation Reports       □ Medications         □ Second and the physical       □ Nursing Notes       □ Diagnosis       □ Barooks Rehab         □ Proyled, 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 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 merry revoke this authorization at any time in writing. I understand the revocation will not apply to information already released in response to this authorization.       Information at any time in writing. I understand the revocation will not apply to information already released in response to this authorization.         1. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization already released in response to this auth	Email Address (Use ALL	CAPS) :					
Description:       Description:       Description:       Date(s) of Service:       Location         □ Admission       □ Consultation Reports       □ Medications       □ Bartram Crossing         □ Documentation       □ Therapy Notes       □ Transfer forms       □ Brooks Rehab         □ History & Physical       □ Nursing Notes       □ Diagnosis       □ Brooks Rehab         □ Progress Notes       □ Clinical Tests       □ Billing Records       □ Outpatient Rehab         □ Discharge Summary       Assessments       □ Other:       □ Outpatient Rehab         □ Inderstand that:       Inderstand that:       Inderstand that:       Inderstand that:         1. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization already released in response to this authorization.       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 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 provpassword.	<ul> <li>Continuation of Care</li> <li>Insurance Purposes</li> <li>Legal Reason</li> <li>Personal Use</li> </ul>	<ul> <li>Copies of Record</li> <li>Review of Record</li> </ul>	provid □ Fax □ Mai □ Pick □ Ema	ed) (Physician Only) led – Paper Copy Up – Paper Cop il (Patient Only/ Encrypted	y Abstract O Unencrypt	nly)	y will be
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				
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       □       Sessments       □       Other:       □       Outpatient Rehab       □       Outpatient Rehab       □       University Crossit         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 already released in response to this authorization.       1       Inderstand that:         1.       My treatment, payment, enrollment or this authorization may be subject to redisclosure by the recipient and not longer protected by state or federal privacy regulations.       .         3.       Information used or disclosed pursuant to this authorization.       .       .       .       .         4.       Upon request, I may view and obtain a copy of the information to be used or disclosed pursuant to this authorizat	Description:	Description:	Descri			Location	I.
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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.	<ol> <li>My treatment, paymen</li> <li>I may revoke this author already released in resp</li> <li>Information used or dis longer protected by sta</li> <li>Upon request, I may vi</li> <li>Upon request, I may re</li> <li>If I fail to specify expin signature date.</li> <li>Patient information pro- password.</li> <li>I understand there are not risks. Risks include, bu</li> </ol>	prization at any time in writin ponse to this authorization. Sclosed pursuant to this authorization te or federal privacy regulation ew and obtain a copy of the inceive a copy of this form after ration date or condition as set povided on a USB flash drive in risks for obtaining my recordent that are not limited to, intercept	g. I unders orization ma ons. nformatior er I sign it. forth belov is for patien s through u	tand the revocation by be subject to re- to be used or dis w, this authorizat nt requests only a nencrypted emai	on will not edisclosure sclosed pur ion is valio and require l and accep	apply to inf e by the recip rsuant to this d for 6 month s decryption ot responsibi	formation pient and no authorization hs from the with a provi lity for those
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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:	<b>Relationship to Patient:</b>		

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Medical Record # Account #