Authorization to Release Medical Records
(Disclosure of Protected Health Information)

Patient Name: _____ Medical Record # _____

Patient Date of Birth: _____ SS# _____

Date(s) of Visit Needed: _____ FIN# _____

I, _____, authorize ❑ Mission Hospitals, Inc. ❑ Other: _____

to share medical records with _____

The medical information or parts of the medical record that will be shared include:

❑ Basic Package or Abstract (dictation, labs, radiology, special procedures, pathology report) ❑ EKG ❑ Whole Chart

❑ Other: _____

The purpose of this release of information is:

❑ Health Care ❑ Legal ❑ Insurance ❑ Personal ❑ Other: _____

I understand that:

- I am authorizing the health care provider listed above to provide copies of my medical record even though it may contain private information about: rape, abuse (sexual, physical, elder, spousal, etc), genetics, abortion, sexual diseases, illnesses like hepatitis or AIDS, ARC (AIDS-related complex), HIV and AIDS testing, substance abuse, and/or mental illness.
- The health care provider listed above has no control over how my medical records will be used by the people who receive them. These people may copy and provide my medical records to other people who do not have to obey state or federal laws protecting the privacy of medical records.
- My decision to sign this authorization will not affect the treatment provided to me by the health care provider, the cost of that treatment, or my benefits.
- I may ask for and get a copy of this authorization.
- A readable photocopy/fax of this authorization shall have the same force and effect as the original.
- This authorization will expire on _____ (or in **six (6) months** if no date or event is written).
- I can cancel this authorization at any time by writing to the health care provider's Privacy Officer or Health Information Management Department at the address listed below. I understand that cancelling will not affect my insurance company's right, if any, to contest a claim under my policy. I also understand that my cancellation may not apply to information already sent out.
- I release the health care provider, its employees, officers and physicians from any legal responsibility or liability for this disclosure to the extent indicated and authorized.

❑ **This authorization will be used to fax emergency information.**

_____ Date: _____
Patient

_____ Date: _____
❑ Parent ❑ Legal Guardian ❑ Executor of Estate ❑ Power of Attorney ❑ Other: _____

_____ Date: _____
Witness

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MISSION HOSPITALS

Mission Hospitals, Inc.
Health Information Management
Asheville, NC 28801

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