Rocky Hill Surgery Center Authorization to Release Protected Health Information

Step 1: Patient Information

_____

Last Name First Name MI. Maiden Name (if applicable)

_____

Address City State Zip Code

_____

Telephone Number Email Address

_____

Date of Birth Social Security Number

Step 2: OBTAIN RECORDS FROM:

_____

Name

_____

Address

_____

City State Zip Code

Phone # _____

Fax # _____

SEND RECORDS TO:

_____

Name

_____

Address

_____

City State Zip Code

Phone # _____

Fax # _____

Step 3: What information is o be released? *Check one or more*

Date(s) of treatment requested: From ___/___/_____ To ___/___/_____

- ☐ Progress Notes
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Other (Specify)_____
- ☐ Operative Note
- ☐ Entire Chart

Step 4: Release of Sensitive information

To the extent that it exists, I authorize the released record to include information about the following, initial all those that may be released.

____Drug or alcohol abuse

____HIV/AIDS

____Mental Health/Psychiatric Disorders

Step 5: Permission and signature

- I authorize the use and disclosure of the individually identifiable health information requested above. I certify that I am making this request voluntarily and that the information above is accurate to the best of my knowledge. This release of information is governed by HIPAA.
- This request will be completed within ten (10) business days.
- I understand that I may revoke this consent in writing, by delivering written notice to RHSC Attn. Privacy Officer. The revocation becomes effective within thirty (30) business days following receipt by RHSC. Such revocation will NOT cover actions which were permitted by this Consent and already taken by RHSC prior to revocation.
- This authorization will expire one year from the date signed below, unless an earlier date is specified here: ____/____/____

Signature of patient or Legal Guardian:_____ Date:_____