SAMARITAN HOSPITAL

Authorization for the Release of Health Information

I hereby authorize ____ (the facility) to disclose my individually identifiable health information as described below.

____

Client's Name   Social Security #   Date of Birth

Name & address of person(s) or organization(s) Requesting records, if different than client.

____

____

____

Name & address of person(s) or organization(s) Receive the records:

____

____

____

_____I will review the records at the facility.

_____I wish to have the following records copied, and I will pick them up at the facility.

_____I am requesting that the facility copy the following records, and send the records to the above address.

Information Requested (please check)

Any/All records from _______________ to _________________ (for 1 year)

I am requesting the following records dated ______________________________

___Ambulance trip sheet	___Discharge summary	___Holter monitor	___PFT, ABG
___Anesthesia record	___EKG/stress test/ECHO	___Lab results	___Physician progress notes
___Clinic notes	___ER report	___MARS	___PT/ST/OT notes
___Consultations	___Face sheet	___Nursing notes	___Social services
___Dialysis records	___H&P	___Operative notes	___Swingbed records
___Delivery room record	___Home health records	___Path reports	___Wellness records
			___X-ray reports

I give special permission to release any information regarding (initial on applicable lines below):

___Substance abuse ___Psychiatric/Mental health info ___HIV info ___STDs ___Physical Abuse/Assault

Other:____

Legal Authority for request (please initial)

_____I am the person (client) noted above.

_____I am the client's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the client's medical records. If a DPAHC is attached, then I have also included evidence that the client's attending physician as determined that the client has lost the capacity to make informed health care decisions.

_____I am the client's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.

_____If the client is deceased: I am the executor/administrator of the client's estate, and I have attached to this authorization a valid appointment as such from a probate court.

Authorization for the Release of Health Information

PATIENT NAME__________________________________

_____The client has executed a legally binding instrument granting me the authority to obtain his/her medical records and I have attached a copy of that instrument to this authorization.

_____The client's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the client's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, e.g., a power of attorney or probate court order.

Understandings & Agreements of Requestor

1. This authorization is voluntary.
2. This authorization will expire one (1) year from the date of my signature below.
3. I understand that I may revoke this authorization at any time by notifying Samaritan Hospital in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the facility for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by Samaritan Hospital if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with Samaritan Hospital.
6. I understand that if I request that records be copied and sent to me that Samaritan Hospital will make a good faith effort to send those records to me in a reasonable amount of time.
7. I understand that if I wish to have copies of records made, then Samaritan Hospital may assess a fee for copying the records, which has been set by the law.
8. I authorize the following ____ to be given copies of my medical records.

Signature of person making request:____Date:________________

Witness:____Date:_________________

ANY REDISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.

____ Drivers License checked