# Authorization for the Disclosure of Protected Health Information "PHI"

Patient Name: _____ Date of Birth: _____

I authorize Gerald Champion Regional Medical Center ("GCRMC") to disclose the health information of the above named individual as described below.

The type of information to be used or disclosed is as follows:

| | | |
|---|---|---|
| ___ Discharge Summary | ___ Radiology Report | ___ Sleep Study Results |
| ___ History & Physical | ___ Laboratory Exams | ___ Emergency Room Record |
| ___ Operative Report | ___ Stress Test Results | ___ Echocardiogram Report |
| ___ Pathology Report | ___ Other (explain) _____ | |

**For services from _____ to _____**
***(Date)*** ***(Date)***

*I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.* _____***(Initial)***

**Specified information is to be disclosed to the following entity or individual:**

_____
*(Name of indicated entity or individual to receive protected health information)*

_____
*(Address)*

_____
*(City,State,Zip)*

For the following purpose(s): _____

I understand that I have the right to revoke this authorization at any time and that I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire:
☐ Upon fulfillment of this request; or ☐ One year from today's date.

I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by Federal confidentiality rules.

**My signature below acknowledges that I have read, understand and authorize the release of my PHI.**

Name of Patient or Personal Representative *(PLEASE PRINT)* _____

Signature of Patient or Personal Representative: _____ Date: _____
(If Personal Representative, include a description of authority to act for patient)

Return this completed form to GCRMC's Health Information Management Department.

If you have any questions, please call 575-443-7800.

*For GCRMC Use Only:* Date that this authorization was received by GCRMC_____

Action taken and date _____

Gerald Champion Regional Medical Center
*Our Family Caring For Yours*

Patient Identification