

**Release of Protected Health Information**

Maryview  DePaul  MIH  Other (State Location)

To release the personal health information of: Patient Name: \_\_\_\_\_  
MR# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Requested \_\_\_\_\_  
Address/City/State/Zip \_\_\_\_\_

To release to:  
Recipient \_\_\_\_\_  
Address/City/State/Zip: \_\_\_\_\_

The purpose of this disclosure is:  At the request of the individual  Other: \_\_\_\_\_  
The dates of patient care covered by this authorization are: \_\_\_\_\_

**Release the following information:**

- Discharge Summary  Pathology Report(s)  Emergency Record(s)  History & Physical
- Radiology Report(s)  Itemized Billing Statement  Consultation(s)  Lab Report(s)
- Operative Report(s)  Cardiology Report(s)  Progress Notes  Treatment Plan(s)
- Other Records as specified: \_\_\_\_\_
- Entire Medical Record (Except for Records Concerning Highly Confidential Information)

**Highly Confidential Information:**

By checking any of the boxes next to a category of Highly Protected Information listed below, I specifically authorize the use and/or disclosure of the category of Highly Protected Information indicated next to the box.:

*(Please check all that apply – leaving a box unchecked may result in no information being disclosed for any purpose)*

- Mental Illness or Development Disability  Abuse of an Adult with a Disability
- Sexually Transmitted Diseases (STDs)  Genetic Testing
- HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported regardless of whether the results of such tests were positive or negative)
- Sexual Assault  Substance (i.e., alcohol or drugs) Abuse
- Child Abuse and Neglect  Psychological Testing or Treatment
- Other Records as specified: \_\_\_\_\_

**This Authorization will remain in effect:**

- From the date this authorization was signed until: \_\_\_\_\_ (not over one (1) year)
- Until the Releasing Entity fulfills the request or you have revoked this authorization

Name of employee who released information: \_\_\_\_\_ Date \_\_\_\_\_

**I understand that:**

- The information released according to your direction may be subject to re-disclosure by the recipient of the information and may no longer be protected by the federal and or state law.
- I may refuse to sign this Authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this Authorization unless my treatment is research-related or I am to receive health care solely for the purpose of creating protected health information for disclosure to the Recipient identified in this Authorization.
- I have the right to revoke this Authorization in writing at any time.** The revocation will be effective immediately upon the Releasing Entity’s receipt of my written notice, except that the revocation will not have any effect on any action taken by the Releasing Entity in reliance on this Authorization before it received my written notice of revocation.
- I may contact one of the Bon Secours Health Information Management Department or Bon Secours Hampton Roads Privacy Office by mail at: BSHR Privacy Officer, 150 Kingsley Lane, Norfolk, VA 23505; by telephone at (866) 873-5799 or through the Value Line at 1-888-880-1286.

I have read and understand the terms of this Authorization, and I hereby knowingly and voluntarily authorize above Releasing Entity to use or disclose my health information in the manner described above.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Signature of Witness\*

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
If Signed by Legal Representative, state Relationship to Patient

\*Witness’ Signature is required for mental health or developmental disability treatment.