TITUSVILLE AREA HOSPITAL | MORE THAN A HOSPITAL
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Authorization to Release Protected Health Information

Form #60079
Rev 1/24

* A U T H R E L E A S E P H I *

I hereby authorize _____(name of facility/provider) to release information from the medical record of:

Patient Name (first, middle initial, & last): _____

Patient Address: _____

Date of Birth: ____/____/____ Patient email address: _____

Phone number: _____ Medical Record Number: _____

1. Dates of service/treatment period: From date: ____/____/____ to ____/____/____
2. Records to be released (check appropriate line):

_____ Discharge Summary _____ Emergency Room Record _____Operative Report _____ Face Sheet

_____ History and Physical _____Consultation _____ Laboratory Record _____ Billing Record

_____ Radiology Report/Disc _____ Cardiopulmonary Record _____Therapy Record

_____ Other (specify document): _____

3. Facility/provider to which records are to be released

_____

4. Reason/purpose records are being released: _____
5. How would you like records to be released? _____ paper _____fax _____radiology disc

_____ email _____other (specify): _____

Patient signature/legal representative: _____

Relationship to patient: _____ Date: _____

This authorization will expire in 60 days after date of signed unless revoked earlier by patient.

This authorization must be signed by the patient or nearest relative/legal representative in the case of a minor or when the patient is physically unable or mentally incompetent to sign. The patient or the patient's legal representative has the right to revoke an authorization in writing to this facility. Any information disclosed following a patient's or their legal representative's authorization may be subject to re-disclosure by the recipient and may no longer be protected by the privacy rule. ***You may refuse to sign this authorization.*** We may not condition treatment on whether or not you sign this authorization.

Office use:
Authorization verification (if verbal authorization - complete 3 of the below listed): _____ photo ID _____ security question _____ phone number _____ last 4 digits of SSN _____ date of birth _____ next of kin _____ piece of mail with name and address other: _____
How was information released? _____ picked up in person _____ emailed (email address above) _____fax (number faxed: _____) _____ mailed
Notify patient:

_____ It is the responsibility of the patient or personal representative to contact Titusville Area Hospital (TAH) Health Information Management Department to revoke a standing request or verbal communication authorization. Employee initial: _____

_____ If delivery by unencrypted email is desired, sender will not be responsible for any breach of protected health information occurring during the electronic transmission of the patient information. Employee initial: _____