APPALACHIAN REGIONAL MEDICAL ASSOCIATES

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (First, Middle, Last)	Date of Birth	Telephone #	
Address	City	State	Zip

I AUTHORIZE: *Provider Authorized to release health information… (Practice Title Required, Provider Name Optional)*

_____

…To release my Protected Health Information "PHI" as described below to: ☐ **Self** (or indicate receiver below)

Receiver	Telephone #	Fax #	
Address	City	State	Zip

For the purpose of: ☐ Personal Copies ☐ Healthcare ☐ Legal ☐ Other: _____

INFORMATION TO BE RELEASED TO RECEIVER

DATE(S) OF TREATMENT: _____

☐ Office Notes ☐ Lab Reports ☐ Radiology Repots ☐ Pathology Reports
☐ Procedure Notes ☐ Radiology Images (Images are disclosed on CD free of charge, the only exception are Harmony images, which can only be disclosed on paper at the normal per page rate for records.)
☐ Other:_____

REQUESTED FORMAT	DELIVERY METHOD
☐ Paper ☐ CD	☐ Pick-Up ☐ US Mail ☐ Fax (to healthcare providers only) ☐ Email
☐ Flash Drive ☐ Email	**Email Address:**_____

My signature below indicates that I understand the following:

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- There is no guarantee of confidentiality when communicating by email. If you ask us to email you protected health information, you understand and agree that neither ARHS, or its affiliates, are responsible for the security and confidentiality of email communications (including attachments) once it leaves our control, including what you do with the information, what happens to the information both in transit and upon arrival, and who else sees the information. By asking us to email you protected health information, you understand and agree to accept these risks.
- I may revoke this authorization at any time by notifying Appalachian Regional Healthcare System and affiliates "ARHS" in writing
- Revoking this authorization will not have any effect on any actions ARHS took before it received the revocation.
- A revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to submit the claim.
- If my record contains sensitive information relating to communicable diseases, HIV status, alcohol/drug abuse, psychological/psychiatric conditions, or genetic testing, this disclosure will include that information.
- ARHS has the right to deny the release of Behavioral Health Records at the discretion of the attending physician.
- I have the right to request a restriction on uses and disclosures of my health information. Except where ARHS is required by law to disclose the information
- I have the right to ask ARHS not to use or disclose certain health information maintained over the course of my care. I understand that to request a restriction, I may complete a Request for Restriction of Protected Health Information form.
- This authorization expires at the time the disclosure of protected health information is completed.
- Fees/charges will comply with all laws and regulations applicable to release of information.

The Healthcare provider listed above is hereby released from all legal liability that may arise from the release of the information requested. I further understand that I may request a copy of this authorization. Please allow up to thirty (30) days to process your request.

▶ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE / TIME

NAME OF LEGAL REPRESENTATIVE RELATIONSHIP OF LEGAL REPRESENTATIVE

▶ _____
SIGNATURE OF WITNESS DATE / TIME

▶ _____
SIGNATURE OF EMPLOYEE COMPLETING AUTHORIZATION (*OFFICE USE ONLY*) DATE / TIME

Effective Date: 06/23/2020
Revised Date: 06/23/2020
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Staff Use Only: Verified Photo ID _____ (Initial Here)

# of pages released_____ MR#_____