Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION AS REQUIRED BY HIPAA PRIVACY RULES

Patient:

Name of Patient _____ Birth Date _____

Street Address _____ City, State, Zip _____

Authorizes:

Name of Health Care Provider _____

Street Address _____

City, State, Zip Code _____

Release Of Protected Health Information To:

Name of Health Care Provider _____

Street Address _____

City, State, Zip Code _____

Information To Be Released:

- ☐ Medical History, Examination, Reports
- ☐ Treatment or Tests
- ☐ Allergy Records
- ☐ Consultations
- ☐ Surgical Reports
- ☐ Hospital Records Including Reports
- ☐ Laboratory Reports
- ☐ Entire Record
- ☐ Immunizations
- ☐ X-ray Reports
- ☐ Prescriptions
- ☐ HIV Results
- ☐ Other (Specify): _____

Purpose For Need Of Disclosure: (Check applicable categories)

- ☐ Further Medical Care
- ☐ Insurance Eligibility/Benefits
- ☐ Legal Investigation or Action
- ☐ Changing Physicians
- ☐ Personal
- ☐ Other (Specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect To This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the medical records department of the Washington Township Medical Foundation. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the medical records department of Washington Township Medical Foundation. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative: _____ **Date:** _____
(If signed by other than patient, state relationship and authority to do so.)

Signature of WTMF Representative: _____ **Date:** _____