Release of Information

Patient Name:_____ Date of Birth:_____
MR#._____

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. This information may relate to treatment for alcohol, drug or psychiatric related illness and/or pertain to results of testing for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC).

□ ER Record:_____ □ Laboratory: _____ □ History/Physical:_____

□ X-Rays: _____ □ Dictation:_____ □ Summary_____

□ Other:_____

1. The information will be used/disclosed for the following purpose (s)
   _____
2. Persons/organizations **authorized to release** or disclose the information:
   _____
3. Persons/organizations **authorized to receive** the information:
   _____
4. The person/organization authorized to use/disclose the information will receive compensation for doing so. □ Yes □ No
5. I understand this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 6 on this form.
6. If the purpose of this authorization is to use and/or disclosure of health information for a research study, and I refuse to sign this authorization, Aspire Rural Health System reserves the right to deny treatment associated with such research.
7. I understand that I may inspect or copy the information used or disclosed.
8. I understand that I may revoke this authorization at any time by notifying Aspire Rural Health System in writing, except to the extent that:
   a. Action has been taken in reliance on this authorization; or
   b. If this authorization is obtained in obtaining insurance coverage.
   c. Other law provides the insurer with the right to consent to obtain health information for processing claims.
9. I understand that I have a right to request and receive a Notice of Privacy Practices from Aspire Rural Health System.
10. This authorization expires within one year of date signed.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient or Patient's Representative Relationship

_____ _____
Signature of Witness Date

Clinic or Department Name:_____ ***Phone number:*** _____
FAX number: _____

Mailing Address:

_____

A copy of this signed form will be provided to the patient upon request.

Patient Name
DOB
MR#
Date