HIGHLANDS MEDICAL CENTER

Authorization for Disclosure of Health Information

1. I hereby authorize Highlands Medical Center to disclose the following information from the health records of:

   Patient Name: _____ DOB: _____ MR# _____

   Address: _____

   Covering the period(s) of healthcare
   From (date) _____ to (date) _____
   From (date) _____ to (date) _____

2. Information to be disclosed:

   ☐ complete health record(s)
   ☐ history & physical examination
   ☐ operative report
   ☐ X-ray reports
   ☐ other (please specify) _____
   ☐ discharge summary
   ☐ progress notes
   ☐ laboratory tests
   ☐ pathology report

   I understand that this will include information relating to (check if applicable):

   ☐ acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
   ☐ behavioral health/psychiatric care
   ☐ treatment for alcohol and/or drug abuse

   This information is protected by federal law. Federal regulations (Title 42 CFR Part 2) prohibit making any further disclosure without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

3. This information is to be disclosed to _____
   for the purpose of _____

4. I understand this authorization may be revoked in writing to Highlands Medical Center at any time, except to the extent that action has been taken in reliance on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal privacy rules. I understand Highlands Medical Center may not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization. Unless otherwise revoked, this authorization will expire 60 days from authorization date.

5. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____
(patient) (Date/Time)

_____
or (legal representative) (relationship to patient) (Date/Time)

_____
(signature of witness) (Date/Time)