Pershing Health System

Information Request – Patient Authorization

Patient Name: _____ MRN: _____

Date of Birth: _____/_____/_____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I request my protected health information (PHI) from Pershing Memorial Hospital be released to:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

☐ Emergency Room Record ☐ Laboratory Report(s) ☐ Detailed Billing

☐ Complete Medical Record (all pages) ☐ Radiology Report(s) ☐ Radiology Discs/Films

☐ Abstract/Hospital Summary (Dictated reports/lab/radiology)

☐ Other _____

Covering the period of health care from:

☐ Specific Date(s): _____ to_____**OR** ☐ All past, present and future encounters/visits

☐ Encounter(s) No.(s): _____

Purpose for requesting information:

☐ Legal ☐ Insurance

☐ Personal ☐ Cont. of Care

How information is to be received (if not marked, paper is default):

☐ US Mail – Paper format ☐ Fax (to healthcare provider only)

☐ E-mail (secure format) ☐ CD –secure electronic format

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative Signature: _____ Date: _____ Time: _____

Printed Name of Authorized Representative: _____ Relationship to patient: _____

Witness Signature: _____ Date: _____ Time: _____

If signed by a patient's authorized representative, supporting legal documentation MUST accompany this authorization form