Breckinridge Health Incorporation

Authorization to Disclose Health Information

1. I hereby authorize(releasing facility) Breckinridge Memorial Hospital to disclose the following information from the health records of:

   Patient Name: _____ Date of Birth: _____

2. Dates of treatment/visit: From(date)_____ to (date)_____

3. Information to be disclosed:

   ___Complete health records
   ___Discharge summary
   ___History & Physical
   ___Consultation report(s)
   ___Lab report(s)
   ___ER
   ___Operative report(s)
   ___Pathology reports(s)
   ___X-ray report(s)
   ___Other (Please specify) _____

   Information is to be released to:

   _____

   _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company where law provides my insurer with the right to contest a claim under my policy.

6. This authorization will expire in 120 days from date of signature.

7. I understand that once the above information is disclosed the recipient may re-disclosed it and the information may not be protected by federal privacy laws or regulations.

8. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Patient or Legal Representation Date

_____

If Signed by Legal Representation, Relation to Patient

_____ _____

Signature of Witness Date