Memorial Hospital OF SWEETWATER COUNTY | Specialty Clinics of Sweetwater Memorial

PATIENT NAME: _____

BIRTHDATE: _____

PATIENT'S CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

TO: (Print / type name & address of health care facility)	RELEASE TO: (Name & address to whom information is to be released)

I request and authorize the above-named health care provider to release the information specified below to the organization / agency / individual I have specified in this request.

Type of Information to be Disclosed: ___ discharge summary, ___ progress notes, ___ assessment information,___ progress in treatment, ___ lab results, ___ urine testing, ___ attendance, ___ pregnancy testing, ___ prenatal care, ___ diagnosis, ___ information on mental illness &/or treatment, ___ other information (specify) _____

Purpose of Disclosure: ___ to coordinate treatment, ___ to gather assessment information, ___ to gather information for ongoing treatment, ___ to report progress, ___ other purposes (specify)_____

Amount of information to be disclosed: ____ information covering admissions this year, ____ information covering the previous three months, ____ other amount of information (specify) _____

I authorize the release of information which may include information regarding the following:

_____ Drug abuse, if any _____ HIV, if any _____ Alcohol abuse, if any _____ Psychiatric conditions, if any

I make this consent upon the promise that all disclosures made pursuant to the authority granted by this consent shall be accompanied by a written notice which states:

> This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., PART 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug client. (These conditions apply to every page disclosed and a copy of this prohibition will accompany every disclosure.)

Date	Signature of Patient
Signature of Releaser	OR Legally responsible person
Expiration Date (Not to exceed 48 months)	Specify Relationship

Revocation: This consent for release of confidential information expires in twelve (12) months, or as authorized by me. Expiration date cannot exceed forty-eight (48) months and will cover only information created twelve (12) months after authorization is signed. I understand I may revoke this Authorization at any time, except to the extent that action has already been taken in compliance with this consent. This facility, its employees, and the attending physician are hereby released from legal responsibility or liability for the release of the above information.

I herby revoke consent in writing:

Date	Signature of Patient/or Legally responsible person

Original - Chart Copy - Patient