Heywood Hospital
Member of the Heywood Healthcare Family

AUTHOHRIZATION FOR THE RELEASE OF MEDICAL INFORMATION

MEDICAL RECORDS NUMBER:

PATIENT IDENTIFICATION:

Name: _____

Date of Birth: _____

Address: _____

_____

Telephone: _____

Email: _____

PURPOSE OF REQUEST:

Medical Treatment: _____ Personal Use: _____

Insurance: _____ Other (please specify): _____

_____

_____

TYPE OF INFORMATION RELEASED:

Date(s) of Treatment(s): _____

Discharge Summary: _____ CardioPulmonary: _____

Operative Reports: _____ X-Ray Reports: _____

Laboratory Reports: _____ Clinic Records: _____

Pathology Reports: _____ Emergency Records: _____

Rehab. Notes: _____ EMG Trac./Reports: _____

Entire Admission: _____

Other (please specify): _____

_____

WHERE DO YOU WANT INFORMATION SENT?

To: _____

Address: _____

_____

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Time Limits:

The authorization is valid for 90 days after the date signed, unless canceled in writing. Please indicate an expiration date if beyond 90 days or state (indefinitely): _____. Expiration Date: _____

The authorization should be dated subsequent to the period of hospitalization for which information is required.

Redisclosure:

Only information related to your care at Heywood Hospital or its Subsidiaries is to be released from your medical records.

We will not release information received from other facilities.

SIGNATURE OF PATIENT OR OTHER LEGALLY APPROPRIATE PARTY

I AGREE TO THE RELEASE OF THIS INFORMATION.

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION IN REFERENCE TO DRUG AND/OR ALCHOL ABUSE, PSYCHIATRIC TREATMENT, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

_____ _____
(Witness Signature) (Date)

AUTHORIZATION FOR PROXY ACCESS TO PATIENT PORT
I authorize the following individual to participate in the Heywood Healthcare System's Patient Portal as my proxy.

_____ _____
(Printed name) (Relationship)

I understand that my proxy will have the same access and privileges that I have for the Patient Portal. I understand that this allows my proxy online access to my personal health information.

By signing this authorization, I am requesting that the Heywood Healthcare System to give access to my proxy to utilize the patient portal. I understand that the Heywood Healthcare System will require my proxy to sign an acknowledgement and agree to it's policies and procedures for use of the patient portal.

This authorization is valid until revoked by me. I understand that a written request is necessary to revoke or cancel this authorization. However, I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy laws/

PATIENT AUTHORIZATION

_____ _____
Signature of Patient (Date)

PROXY ACKNOWLEDGEMENT

_____ _____
Signature of Proxy (Date)

RELEASE OF AHIV (AIDS) TEST RESULTS

I Agree to the release of my AHIV (AIDS) test results

_____ _____
(Signature of Patient or Legal Guardian) (Date)

Identification viewed: License: _____ Other (please explain): _____

Authorization received by: _____ Date:_____

Document Prepared by: _____ Date:_____

PLACED IN A SEALED ENVELOPE: _____ (Please initial)