*release*

## AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS

*(medical record number)* ________________ (*Date requested)*_________________

I: ________________________________________________________ ________________
*(Full name of patient)* *(Date of birth)*

I authorize ❒ Oaklawn Hospital to use/disclose my health information (as outlined below)
❒ Other: ________________________ to use/disclose my health information (as outlined below)
TO: ❒ Receiving Party: _____________________________________ ❒ Oakland Hospital
_____________________________________
_____________________________________

### Specific types of information to be disclosed (include *dates of treatment, check all that apply)*

*I understand that unless otherwise indicated or specified here, a request for disclosure or release of "all" or "any" medical records or health information may include information regarding drug and/or alcohol treatment, social service or mental health records, communications made to a social worker and HIV/AIDs and AIDS related complex information or documentation, if such information exists.*

❒ History/Physical ❒ Discharge Summary ❒ Operative/Path report ❒ Psychotherapy notes
❒ Emergency Department record______________ ❒ Diagnostic testing (lab, x-ray, cardio)_______
❒ Mental health ❒ HIV/HIDS, and AIDs ❒ Drug and/or alcohol treatment
❒ Complete record (including mental health) ❒ Other __________________________________

**Purpose and need for disclosure:** ❒ Continuing care ❒ Insurance billing ❒ Disability ❒ Personal Use
❒ Marketing purposes ❒ Application for employment ❒ Fundraising activities ❒ Enrollment in a Health Plan
❒ Other: ________________________________________________________________________________

*I understand that I may revoke this authorization at any time by sending a written revocation to Oaklawn Hospital except to the extent that Oaklawn Hospital has taken action in reliance on the authorization.*

*I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving party and may no longer be protected by federal or state law.*

*I understand that my continued or future treatment by Oaklawn Hospital is not conditional upon my providing or signing this authorization unless this authorization is providing data in connection with medical or clinical trial research.*

*I understand that if Oaklawn Hospital is the Receiving Party, I have the right to inspect or copy the health information Oaklawn Hospital intends to use or disclose, pursuant to this authorization and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.*

*I understand that my authorization of the use or disclosure of my health information as indicated in this document may allow financial gain.*

*This authorization is made in accordance with federal and state law and is valid for a period of one year after being executed; however, it may be revoked by me at any time by providing written notice to the above named party. A facsimile or photocopy of this document will be accepted in lieu of the original.*

________________________________________________ ________________ ______________
Patient Signature or Legal Guardian (Date/Time) ID Number

________________________________________________ ________________
(Witnessed by) (Date/Time)

Any request by email may be sent to **medicalrecords@oaklawnhospital.com**.


**Health Information Management**
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