



AUTHORIZATION FOR RELEASE OF INFORMATION Date of Birth Patient Name Sex Address City State Zip I hereby authorize DECATUR MORGAN HOSPITAL/DECATUR MORGAN EMPLOYED PHYSICIAN NETWORK to: ☐ RELEASE TO (and/or) **□** OBTAIN FROM Name Address City State Zip The following information pertaining to treatment: Date Admitted Date Discharged_ ■ Acknowledgment of Admission and Discharge Operative Note ☐ History & Physical □ Pathology Report Discharge Summary □ Imaging Report ■ Emergency Room Record-Dates ☐ Lab ■ Other (specify) PURPOSE FOR DISCLOSURE 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. I UNDERSTAND THAT THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE NINETY (90) DAYS FROM DATE SIGNED. I authorize the use or disclosure of my protected health information (PHI) as described. I understand that the information I authorize a person or entity to receive may be **re-disclosed** and is no longer protected by federal privacy regulations. It is often necessary to release your health information via facsimile when it is needed for continuing care and other circumstances that require immediate attention. I authorize transmission of my health records in situations where this information is needed under the above circumstances. **REVOCATION:** This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken. Written revocation should be provided to the Director of Health Information Management at the above address. I understand that authorizing the disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used on disclosure as provided in CFR 164.524. If I have guestions about disclosure of my health records, I may contact the Health Information Director at 256-973-2125. Patient or person authorized to sign for patient Date Time Witness Time Date Reason patient unable to sign Interpreter's name (Please print) Interpreter's Number If professional interpreter, name of company

Original--Chart

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Refused interpretation – waiver interpreted, signed and in Medical Record

