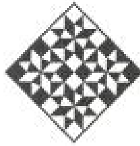

HOT SPRINGS HEALTH PROGRAM

Administration
PO Box 69
Marshall, NC 28753
Phone: 828-649-9566
Fax: 828-649-3786

Hot Springs Medical Center
PO Box 69
Marshall, NC 28753
Phone: 828-622-3245
Fax: 828-622-7446

Laurel Medical Center
PO Box 69
Marshall, NC 28753
Phone: 828-656-2611
Fax: 828-656-9434

Mars Hill Medical Center
PO Box 69
Marshall, NC 28753
Phone: 828-689-3507
Fax: 828-689-3505

Mashburn Medical Center
PO Box 69
Marshall, NC 28753
Phone: 828-649-3500
Fax: 828-649-1032

Madison Home Care & Hospice
PO Box 69
Marshall, NC 28753
Phone: 828-649-2705
Fax: 828-649-0687

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ DOB: ______________
Address: ______________________ SS#: ______________
______________________ Ph#: ______________

I am either the patient named above or the personal representative who can legally act for the patient. I give permission for ____
____ to share with
(Complete Name of Person, Agency, Facility and address, DO NOT Abbreviate)
____ the protected health information named below.
(Complete Name of Person, Agency, Facility Requesting Information, Including Address, Phone#, DO NOT Abbreviate)

The information and dates of service checked below will be shared: The information will be used for:

Information	Dates	Information	Dates	
__Discharge summaries	______	__Complete health record	______	__Case management
__Clinical lab reports	______	__Consultation reports	______	__Assessment
__X-ray reports	______	__Progress notes	______	__Development of plan for continuing care
__History & physical	______	__Medication history	______	__Establishment of care for new patient
__Photographs, videotapes digital or other images	______	__Immunization	______	__Unknown (the info. is being shared at the request of the patient of patient's personal rep)
__Other______________				__Other______________

Sensitive information may be included in the patient's record. By initialing next to each type of sensitive information listed below, I am agreeing that sensitive information of that type may be shared.

Patient or Patient's Personal Representative is to INITIAL next to the type of sensitive information that may be shared.

	Initials		Initials
Communicable Disease Including HIB/STD	______	**Pregnancy**	______
Mental Health/Development Disabilities	______	**Family Planning**	______
Alcohol & Drug Abuse	______		

- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulation, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Hot Springs Health Program's Privacy Officer in writing. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Hot Springs Health Program before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I understand this authorization will expire (check and complete one):

__ Once the above is completed; or
__ No expiration. This is an ongoing authorization for future releases unless revoked; or
__ Other: ____

______________________________ ______________
Signature of Patient or Personal Representative Date

____
Printed Name of Personal Representative and Relationship to Patient (Parent, Guardian, POA, etc)

______________________________ ______________
Patient/Patient's Personal Representative Identity Verified By Date of Release