HOT SPRINGS HEALTH PROGRAM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please mail all correspondence to:
P.O. Box 69
Marshall, NC 28753

Medical Records Fax:
828-649-2780

Hot Springs Medical
Phone: 828-622-3245

Laurel Medical
Phone: 828-656-2611

Mars Hill Medical
Phone: 828-689-3507

Mashburn Medical
Phone: 828-649-3500

For Medical Records faxed to Madison Home Care & Hospice or Outpatient Therapy please see below:

Madison Home Care & Hospice
Phone: 828-649-2705
Fax: 828:649-0687

Outpatient Therapy
Phone: 828-649-1775
Fax: 828-398-4201

Patient Name: _____ DOB: _____
Address: _____ Phone: _____
_____

I am either the patient named above or the personal representative who can legally act for the patient. I give permission for ☐ ***Hot Springs Health Program, Outpatient Therapy Services, and/or Madison Home Care & Hospice OR (other facility)*** _____ to share with ☐ ***Hot Springs Health Program, Outpatient Therapy Services, and/or Madison Home Care & Hospice*** **OR (*other facility*)** _____ the protected health information named below. (Complete name of person, agency, facility requesting information, including address, and phone#, do not abbreviate.)

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

Information	Dates	Information	Dates
☐ Discharge summaries		☐ Complete health record	
☐ Clinical lab reports		☐ Consultation reports	
☐ X-ray reports		☐ Progress notes	
☐ History& Physical		☐ Medication history	
☐ Photographs, videotapes, digital, or other images		☐ Immunization	
☐ Other			

The information will be used for:

☐ Case Management
☐ Assessment
☐ Development of plan for continuing care
☐ Establishment of care for new patient
☐ Unknown (The info. Is being shared at the request of the patient or patient's personal rep.)
☐ 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 HIV/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 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 effect 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 Relationship to Patient (Parent, Guardian, POA)

_____ _____
Patient/Patient's Personal Representative Identity verified by Date of Release