THE BELLEVUE HOSPITAL
AUTHORIZATION FOR USE AND DISCLOSURE OF PATIENT INFORMATION

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Telephone Number for Contact: _____

Mode of Release: □ Mail □Pick Up □Faxed: _____

I hereby authorize The Bellevue Hospital to use or disclose personal health information about me as described below:

□ History & Physical – Date(s) of Service: _____
□ Discharge Summary – Date(s) of Service: _____
□ Operative Report – Date(s) of Service: _____
□ Laboratory Results – Date(s) of Service: _____
□ Radiology Results – Date(s) of Service: _____
□ Emergency Department Record – Date(s) of Service: _____
□ Entire Medical Record – Date of Service(s): _____
□ Other (specify, with Date(s) of Service): _____

CHECK ONE:

□ Sensitive information regarding HIV/AIDS, or treatment for substance abuse (alcoholism or drug abuse) and/or mental health issues may be disclosed.

□ I do not authorize the release of sensitive information regarding HIV/AIDS, or treatment for substance abuse and/or mental health.

Release this information to:
Name: _____
Address: _____
City, State, Zip: _____

The purpose of the authorized use or disclosure of the information described above is as follows:

□ Personal Use
□ Sharing with other healthcare provider
□ Other (specify): _____

I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by federal privacy regulations.

I understand that I am not required to sign this authorization form and that The Bellevue Hospital will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.

As described in the Notice of Privacy Practices of The Bellevue Hospital, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by The Bellevue Hospital in reliance on this authorization, by sending a written revocation to the Privacy Officer of The Bellevue Hospital, 1400 West Main Street, P.O. Box 8004, Bellevue, OH 44811-8004.

I understand, unless I specify differently, that this authorization will expire one year from the date signed.

If you are the representative of a patient, describe the scope of your authority to act on the patient's behalf:

□ Parent
□ Durable Power of Attorney for Healthcare
□ Other (specify): _____

_____ _____
Signature of Patient (or Patient's Representative) Date

_____ _____
Signature of The Bellevue Hospital Representative Date