MARIST Health Services

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

1. I authorize ___ Marist Health Services OR ___ Other: ____
____

2. To disclose the protected health information of

   Name __________________________________ CWID_____________________ Date of birth ______________
   Address _________________________________ CITY _____________________ STATE ___________________
   __________________________________ ZIP CODE ___________________ PHONE___________________

3. To the following individual or organization:
   Name____
   Address____
   Phone _____________________________________ Fax _____________________________________

4. Purpose of the disclosure:
   ___ further health care ___ insurance documentation ___ legal investigation
   ___ academic accommodation ___ personal use ___ coordination of services
   ___ other ____,

5. Information to be disclosed
   Incoming immunization record only
   Treatment dates____
   ___ clinical notes ___ lab reports ___ radiology reports

   ___ other ____

6. I understand that
   a. I may revoke this authorization at any time. The revocation will not apply to information that has already been released in response to this authorization. I must revoke this authorization in writing.
   b. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient of such information. It is possible that, once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.
   c. Unless otherwise revoked, this authorization will expire on (date or event)_______________________. If I fail to specify an expiration date or event, this authorization will expire one (1) year from the date of my signature.
7. I have read and understand the information in this authorization form.

Signature ____ Date _____________________

Witness ____ Date _____________________

Director/Dean must sign for any release other than immunization records ____

Action to be taken ___ fax ___ copy and mail ___ oral/phone disclose only ___ obtain records indicated above
Records were ___ discussed ___ faxed ___ mailed ___ picked up on _______________ Initials _________________
Record request was ___ discussed ___ faxed ___ mailed ___ picked up on _______________ Initials _________________

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