Beebe Healthcare

Authorization for Release of Protected Health Information

Medical Record #

SECTION A: PATIENT INFORMATON	
Patient Name	**Birth Date:**
Address:	**Phone:**
SECTION B: INFORMATON BEING RELEASED TO:	
Recipient Name:	**Fax:**
Address:	
Phone:	**Attention to:**

I hereby authorize and request (check below) to disclose information related to treatment at:

☐Margaret H. Rollins Health Campus ☐Tunnell Cancer Center ☐Home Care ☐Rehabilitation ☐Walk-In

☐Beebe Medical Group (specify): _____

☐South Coastal Health Campus ☐Abessinio Health Campus ☐ Other:_____

_____

Treatment Date (specify): _____

☐Abstract (Face Sheet, History & Physical, Emergency Note, Discharge Summary, Consult, Test results, Operative note)

☐Consultation Report ☐Billing Record ☐Oncology Records: _____

☐Cardiac Test _____ ☐Images (Radiology | Cardiology) ☐Pathology Reports/Slides

☐Discharge Summary ☐Laboratory Report ☐Radiology Reports

☐EEG ☐EKG ☐Medication Record ☐Office Notes

☐Emergency Room Record ☐Operative| Procedure Report ☐Office Tests/Immunizations

☐Other

Special Instructions:

I specifically authorize the use and or disclosure of the following highly confidential information related to behavioral and mental health, genetic testing, HIV/AIDS, sexually transmitted diagnosis/treatment, drug/alcohol use and treatment, STD and any Reproductive Health indicated by in the check box below:

☐Behavioral Health ☐Genetic Testing ☐HIV/AIDS ☐Drug and/or Alcohol ☐Sexually Transmitted Disease ☐Reproductive Health

SECTION C: PURPOSE

☐Continuing Care ☐Personal Use ☐Insurance ☐Legal ☐Other(specify):

SECTION D: FORMAT AND DELIVERY TYPE

☐ Paper ☐DVD ☐Patient Portal

☐ *Encrypted Email (specify): _____

☐ Pick Up ☐Mail

**Note: Choosing encrypted email delivery involves some level of risk to you. Beebe Healthcare is not responsible for unauthorized access to PHI contained in this format or any risks potentially introduced to your computer/device when receiving PHI in electronic format/email.*

SECTION E: ACKNOWLEDGEMENT AND APPROVAL

I understand that this authorization is valid for 6 months from the date I signed unless a date is specified here: _____

I understand that I may revoke the authorization in writing at any time. You may mail your revocation in writing to: Health Information Management, 424 Savannah Road, Lewes, DE 19958 to the attention of the HIM Director.

I understand that Beebe Healthcare cannot guarantee that the recipient identified will not re-disclose and is no longer protected by the Privacy Rule.

I understand that my refusal to sign this authorization Beebe Healthcare may not condition treatment, payment, enrollment, or eligibility for health care benefits.

I understand that I have the right to receive a copy of this authorization.

I understand that I have the right to inspect/receive a copy of the health information, and that I may be charged a reasonable fee for copies of medical records that I receive allowable by law.

Signature of Patient:	**Date:**
Personal Representative Signature: ☐ Parent ☐Legal Guardian ☐Health Care Proxy ☐Foster Parent ☐Other:	**Date:**

The signature of a minor at age 12 or above is required for confidential health records according to state law.

ADM0101