

# TWIN CITIES HOSPITAL

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

|  |                 |  |                 |  |                 |
|--|-----------------|--|-----------------|--|-----------------|
| <b>Section A: This section must be completed for all Authorizations</b>  |                 |  |                 |  |                 |
| <b>Patient Name:</b>   |                 | <b>Birth Date:</b>   |                 | <b>Social Security No. (optional):</b>   |                 |
| <b>Provider's Name:</b><br>Twin Cities Hospital  |                 | <b>Recipient's Name:</b>   |                 |  |                 |
| <b>Provider's Address:</b>   |                 | <b>Address 1:</b>  |                 |  |                 |
| 2190 Hwy 85 North  |                 | <b>Address 2:</b>  |                 |  |                 |
| Niceville, Fl 32578  |                 | <b>City:</b>   |                 | <b>State:</b>  | <b>Zip:</b>     |
| This authorization will expire on the following: (Fill in the Date or the Event but not both.)   |                 |  |                 |  |                 |
| <b>Date:</b>   |                 |  | <b>Event:</b>   |  |                 |
| <b>Purpose of disclosure:</b>  |                 |  |                 |  |                 |
| <b>Description of information to be used or disclosed</b>  |                 |  |                 |  |                 |
| Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.   |                 |  |                 |  |                 |
| <b>Description:</b>  | <b>Date(s):</b> | <b>Description:</b>  | <b>Date(s):</b> | <b>Description:</b>  | <b>Date(s):</b> |
| <input type="checkbox"/> All PHI in medical record<br><input type="checkbox"/> Admission form<br><input type="checkbox"/> Dictation reports<br><input type="checkbox"/> Physician orders<br><input type="checkbox"/> Intake/outtake<br><input type="checkbox"/> Clinical Test<br><input type="checkbox"/> Medication Sheets  |                 | <input type="checkbox"/> Operative Information<br><input type="checkbox"/> Cath lab<br><input type="checkbox"/> Special test/therapy<br><input type="checkbox"/> Rhythm Strips<br><input type="checkbox"/> Nursing Information<br><input type="checkbox"/> Transfer forms<br><input type="checkbox"/> ER Information |                 | <input type="checkbox"/> Labor/delivery sum.<br><input type="checkbox"/> OB nursing assess<br><input type="checkbox"/> Postpartum flow sheet<br><input type="checkbox"/> Itemized bill:<br><input type="checkbox"/> UB-92:<br><input type="checkbox"/> Other:<br><input type="checkbox"/> Other: |                 |
| I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/>   |                 |  |                 |  |                 |
| I understand that:   |                 |  |                 |  |                 |
| <ol style="list-style-type: none"> <li>1. I may refuse to sign this authorization and that it is strictly voluntary.</li> <li>2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.</li> <li>3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.</li> <li>4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.</li> <li>5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.</li> <li>6. I get a copy of this form after I sign it.</li> </ol> |                 |  |                 |  |                 |
| <b>Section B: Is the request of PHI for the purpose of marketing?</b>  |                 |  |                 |  |                 |
| If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.  |                 |  |                 |  |                 |
| Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?   |                 |  |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   |                 |
| If yes, describe:  |                 |  |                 |  |                 |
| <b>Section C: Signatures</b>   |                 |  |                 |  |                 |
| I have read the above and authorize the disclosure of the protected health information as stated.  |                 |  |                 |  |                 |
| <b>Signature of Patient/Patient's Representative:</b>  |                 |  |                 | <b>Date:</b>   |                 |
| <b>Print Name of Patient's Representative:</b>   |                 |  |                 | <b>Relationship to Patient:</b>  |                 |

