AUTHORIZATION FOR THE USE OF DISCLOSURE
OF PROTECTED HEALTH INFORMATION

_____ _____ _____
(Patient Name) (Date of Birth) (Date of Admission)

I hereby freely and voluntarily authorize Brentwood Hospital. to:
_____ Release/disclose records of my health information to:
_____ Obtain records of my health information from:

_____ ( )
(Individual, Facility, Organization) (Telephone Number)

_____ ( )
(Address) (Fax Number)

_____
(City, State, Zip)

The purpose for this disclosure is:

- o To assist in continuing care
- o To assist in treatment planning
- o To keep the above informed of patient's progress
- o Other (specify)_____
- o To assist in legal investigation
- o To coordinate discharge planning/placement
- o To assist in patient use

The information to be released/obtained included:

- o Discharge Summary
- o Lab, X-rays, EEG, EKG
- o Psychological Testing
- o Treatment Plans
- o History and Physical
- o Immunization Record
- o Psychiatric Evaluation
- o Verbal exchange of information
- o Substance Abuse Treatment
- o Educational Assessments/Testing/Evaluations and Records
- o Transition of Care Packet (Discharge Plan Part 1, After Care/Discharge Plan Part II, Medication Reconciliation Document, Patient Safety Plan an Patient Advance Directives Acknowledgements)
- o Other (specify)_____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not rediscover them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law. This consent expires on (date):_____

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/If Authorized Representative (Describe:_____) Date

_____ _____
Witness Signature Date

*Drug/Alcohol records are protected by Federal confidentiality rules (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigation or prosecute any alcohol or drug abuse resident.