AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient: ______________________ Date of Birth: ____________
Address: ______________________
______________________ Medical Record #:____________________
Telephone: ______________________

Other names under which the patient has been treated: ______________________

I authorize Boundary Community Hospital, and any of its affiliated entities, employees, agents or associated health care practitioners (collectively "Boundary Community Hospital") to use or disclose the patient's protected health information as described below.

1. Boundary Community Hospital may use or disclose information that relates to the following time period:
   - ❑ The patient's health care at anytime.
   - ❑ The patient's health care between (*date*) ____________ and (*date*) ____________.

2. Boundary Community Hospital may use or disclose the following type(s) of information per this authorization:
   - ❑ Any information concerning the patient's health, health care, or payment during the relevant time period.
   - ❑ Only the following health care records from the relevant time period:
     - ❑ Discharge summaries
     - ❑ History and physicals
     - ❑ Consultation reports
     - ❑ Procedure reports
     - ❑ Emergency service reports
     - ❑ Pathology reports
     - ❑ Laboratory reports
     - ❑ Diagnostic test reports
     - ❑ Diagnostic imaging studies and reports
     - ❑ X-ray films
     - ❑ Psychotherapy notes *(cannot be combined with an authorization for other records)*
     - ❑ Other: ______________
   - ❑ Billing and payment records for care rendered during the relevant time period.
   - ❑ Other: ______________________

3. Boundary Community Hospital may disclose the information to the following person(s) or entity(ies) per this authorization:
   Name or description: ______________________
   Address: ______________________
   ____
   Phone number: ______________________

4. Boundary Community Hospital may use or disclose the information per this authorization for the following purpose(s):
   - ❑ The disclosure is made at my request.
   - ❑ For a potential or pending legal proceeding.
   - ❑ For marketing. Boundary Community Hospital *will/will not (circle one)* receive remuneration from a third Boundary Community Hospital party for the use or disclosure of the information.
   - ❑ Other: ______________________

I understand that I have the right to revoke this authorization at anytime except to the extent that Boundary Community Hospital has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to: Boundary Community Hospital Medical Records Department.

I understand that Boundary Community Hospital may not condition the patient's health care on this authorization unless (1) the purpose for Boundary Community Hospital's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by Boundary Community Hospital pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

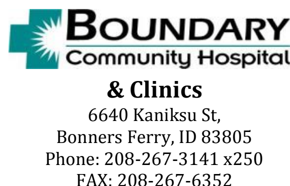
This authorization will expire on the following date or event: ______________________. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

______________________ ______________________
Signature Date

____
Authority or relationship to the patient

** Give a copy of the authorization to the patient or personal representative.*

MEDICAL RECORD DEPT USE ONLY
ROI Request #:______________
Date Released: ______________
Number of pages released:__________
Released by: ______________________
Validated by:______________________



& Clinics
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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