TRAINING UPDATE

Lab Location:	SGMC & WAH	**Date Distributed:**	3/5/2019
Department:	OP Lab staff	**Due Date:**	3/31/2019
		Implementation:	**3/4/2019**

DESCRIPTION

Name:

PHI Authorization form, SGMC AG.F434.1
PHI Authorization form, WAH AG.F435.1

Description of change(s):

These are NEW forms that replace our current Quest versions. Effective immediately we will use the site-specific Adventist Hospital forms when patients request copies of their lab results or ask results to be sent to other physicians.

Document your compliance with this training update by taking the quiz in the MTS system.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM SHADY GROVE MEDICAL CENTER

Please Print Clearly

Name ____
Last First Initial

Address ____
Street City State zip code

Telephone ( ) ____________________ Birth Date__________________ Medical Record # ______________________________

I authorize Shady Grove Medical Center to disclose the above named health information to:

Name of Doctor, Hospital, etc. ____
Address ____
City/State/Zip Code ____

The type and amount of information to be used or disclosed is as follows: (please check)

- ☐ H&P
- ☐ Labs
- ☐ Entire record
- ☐ Discharge Summary
- ☐ X-rays/X-Ray Films
- ☐ Specific information (please specify)
- ☐ Progress Notes
- ☐ Billing Records

I give special permission to release any information regarding: (please check)

- ☐ Substance abuse
- ☐ HIV Information
- ☐ Psychiatric/Mental Health Information
- ☐ Psychological/Neuropsychological
- ☐ Psychotherapy

Reason for Disclosure/Dates of treatment for request: ____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Unless revoked this authorization will expire on the following date, event or condition ______________________________
If I fail to specify an expiration date, this authorization will automatically expire one year from the date signed. I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. If I have a question about disclosure of my health information, I can contact the HIM Director or Chief Privacy Officer.

Information that has been disclosed to you may be protected by Federal Confidentiality regulations (42 CFR Part 2). Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any patient receiving alcohol or drug abuse treatment.

Patient Signature ____ Date ______________________

Legal Representative ____ Date ______________________
(State Relationship)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM SHADY GROVE MEDICAL CENTER

7680-106 (05/16)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM WASHINGTON ADVENTIST HOSPITAL

Please Print Clearly

Name ____
Last First Initial

Address ____
Street City State zip code

Telephone ( ) ____________ Birth Date____________ Medical Record # ____________

I authorize Washington Adventist Hospital to disclose the above named health information to:

Name of Doctor, Hospital, etc. ______________________________

Address ______________________________

City/State/Zip Code______________________________

The type and amount of information to be used or disclosed is as follows: (please check)

☐ H&P ☐ Discharge Summary ☐ Progress Notes
☐ Labs ☐ X-rays/X-Ray Films ☐ Billing Records
☐ Entire record ☐ Specific information (please specify) ______________

I give **special** permission to release any information regarding: (please check)

☐ Substance abuse ☐ Psychiatric/Mental Health Information ☐ Psychotherapy
☐ HIV Information ☐ Psychological/Neuropsychological

Reason for Disclosure/Dates of treatment for request: ______________________________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Unless revoked this authorization will expire on the following date, event or condition ______________
If I fail to specify an expiration date, this authorization will automatically expire one year from the date signed. I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. If I have a question about disclosure of my health information, I can contact the HIM Director or Chief Privacy Officer.

Information that has been disclosed to you may be protected by Federal Confidentiality regulations (42 CFR Part 2). Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal regulations restrict any use of the information to criminally investigate or prosecute any patient receiving alcohol or drug abuse treatment.

Patient Signature ______________________________ Date ______________

Legal Representative ______________________________ Date______________
(State Relationship)

Patient Identification

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM WASHINGTON ADVENTIST HOSPITAL

W7680106 (05/16)