### TRAINING UPDATE

Lab Location: Department: SGMC & WAH OP Lab staff

Date Distributed:
Due Date:
Implementation:

3/5/2019 3/31/2019 **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

Nama			•		
NameLast		First		Initial	
Address					
	Street	City	State	zip code	
Telephone ( )		Birth Date	_ Medical Record #		
Name o	f Doctor, Hospital, etc	disclose the above named health in			
The type and am ☐ H&F ☐ Labs	ount of information to be u	used or disclosed is as follows: (plane)  Discharge Summary  X-rays/X-Ray Films  Specific information (please s	ease check)  Progress  Billing R	Notes	
give special per Subs	rmission to release any info stance abuse Information	ormation regarding: (please check) Psychiatric/Mental Health Inf Psychological/Neuropsych		nerapy	
Reason for Discl	osure/Dates of treatment for	or request:			
writing and pres apply to informa insurance compa authorized to re	ent my written revocation tion that has already been a ny when the law provides a ceive the information is n	to the health information manage released in response to this authori my insurer with the right to contest	ment department. I un- zation. I understand tha a claim under my policy	oke this authorization I must do so in derstand that the revocation will not at the revocation will not apply to my I understand that if the organization ral privacy regulations, the released	
If I fail to specify the disclosure of assure treatment.	an expiration date, this aut this health information is I understand that I may in	voluntary and that I can refuse to	e one year from the date sign this authorization. e used or disclosed, as p	signed. I understand that authorizing I need not sign this form in order to provided in CFR 164-524. If I have a Officer.	
you from making to whom it perta not sufficient for	g further disclosure of this ins or as otherwise permitt	information unless further disclosured by the regulations. A general au	re is expressly permitted thorization for the relea	2 CFR Part 2). Federal rules prohibit I by the written consent of the person se of medical or other information is y investigate or prosecute any patient	
Patient Signature			Date		
Legal Representa	ative		Date		
	(5	State Relationship)			



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM SHADY GROVE MEDICAL CENTER

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# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM WASHINGTON ADVENTIST HOSPITAL

## **Please Print Clearly**

Name				
Last	First		Initial	
Address		G:	Q.	
Street		City	State	zip code
Telephone ( )	Birth Date		Medical Record #_	
I authorize Washington Adventist Hospital	to disclose the above 1	named health is	nformation 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: (plea	se check)	
☐ H&P	☐ Discharge Summary		☐ Progress Notes	
☐ Labs			☐ Billing Records	
☐ Entire record	☐ Specific information	on (please spec	ify)	
I give <b>special</b> permission to release any in	formation regarding: (r	lease check)		
☐ Substance abuse	☐ Psychiatric/Mental		nation	☐ Psychotherapy
☐ HIV Information	☐ Psychological/Neu	ropsychologic	al	
Reason for Disclosure/Dates of treatment	for request:			
I understand that I have the right to revoke writing and present my written revocation apply to information that has already beer my insurance company when the law pro organization authorized to receive the info released information may no longer be pro	to the health information released in response to vides my insurer with rmation is not a health	on management of this authorizathe right to copplan or health	nt department. I un ation. I understand ntest a claim under care provider covere	derstand that the revocation will not that the revocation will not apply to my policy. I understand that if the
Unless revoked this authorization will exp If I fail to specify an expiration date, this authorizing the disclosure of this health into in order to assure treatment. I understand 524. If I have a question about disclosure	s authorization will au formation is voluntary a that I may inspect or c	tomatically ex and that I can re copy the inforn	pire one year from efuse to sign this aut nation to be used or	the date signed. I understand that thorization. I need not sign this form disclosed, as provided in CFR 164-
Information that has been disclosed to you you from making further disclosure of th person to whom it pertains or as otherwi information is not sufficient for this purp prosecute any patient receiving alcohol or	is information unless f se permitted by the re- ose. The Federal regul	urther disclosu gulations. A ge	re is expressly peri eneral authorization	mitted by the written consent of the for the release of medical or other
Patient Signature			Date	
Legal Representative	(State Relationship)		Date	

Patient Identification

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM WASHINGTON ADVENTIST HOSPITAL

W7680106 (05/16)