LITTLE COMPANY OF MARY
AUTHORIZATION TO OBTAIN OR FURNISH
PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Pick Up ❑ Mail ❑ Medical Record Number _____

Treated From _____ (date) To _____ (date)

I hereby authorize the protected health information regarding the above-named person be forwarded:

FROM: (Sender) Name of Person/Institution _____

Attention _____

Address _____

City _____ State _____ ZIP _____

TO: (Recipient) Name of Person/Institution _____

Attention _____

Address _____

City _____ State _____ ZIP _____

Information Requested (We cannot release information unless each applicable box corresponding to that information is checked.)

❑ Consultations ❑ Emergency Dept. Report ❑ Lab/Pathology Reports ❑ Progress Notes/Physician/Nurse
❑ Discharge Summary ❑ Face Sheet ❑ Operative Report ❑ X-ray/Radiology Reports
❑ EKG/EMG/EEG Reports ❑ History & Physical ❑ Physician Orders ❑ Other _____

I understand the information to be released may include: (initial all that apply)

_____ Genetic Test Results
_____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse
_____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment
_____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

Express Purpose for Disclosure: _____

Inspection: I authorize inspection of the above records and necessary copying of same to accomplish the purpose for which the information is being disclosed. I understand that under applicable law, I have the right to inspect and copy the information to be furnished or released unless I am under the age of 12 or unless the health care professional responsible for my treatment determines in writing that access to the information would be detrimental to my health.

Duration of Consent and Right of Revocation: I understand this authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. This authorization form is valid until (fill in a date that is within one year after signing) _____/_____/_____ (will be one year after signing unless specified). I reserve the right to revoke the consent at any time. I understand that Little Company of Mary may not condition treatment or payment on my executing this authorization.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Parent/Guardian or Representative Relationship to Patient Date
(Generally required if patient is under 18 years old or incompetent.)

_____ _____
Signature of Therapist (if applicable) Date

_____ _____
Signature of Witness Date

Redisclosure: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient names above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.

(1) Original in the Medical Record (2) Copy to the Patient

Form 0038497