1. Patient Information	
Name *(First, Middle, Last)*	Medical Record #
Current Address	City State Zip
Email	Phone Number ( ) Date of Birth / /

2. Release Information From (check all that apply):	3. Release Information To:
☐ Holy Cross Hospital **OR**	Name of Recipient
☐ Specify Holy Cross facility(ies):_____	Address City/State Zip
_____	Phone Number ( ) Fax Number ( )
_____	Select one: ☐ Paper ☐ Secure electronic delivery (If electronic, provide recipient's email):

Purpose for Disclosure: _____
(Purpose for disclosure must be completed prior to processing, e.g., continuing care, personal use, legal)

Dates of service to release (FROM): _____**(TO):**_____

☐ Office Visits	☐ History & Physical	☐ Physical/Occupational Therapy Reports
☐ Emergency Department Reports	☐ Cardiac Reports	☐ Homecare Records
☐ Discharge Summary	☐ Laboratory Reports	☐ Radiation Oncology Records
☐ Operative Reports	☐ Radiology Reports	☐ Other_____

I, the undersigned, authorize Holy Cross Hospital to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not e based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and my no longer be protected by law. the recipient of my health information may be charged for the service of releasing medical information. there is no charge to send records directly to my health care provider.
If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_____/_____/_____
Signature of Patient/Patient's Personal Representative** Printed Name Date Signed

_____
Relationship, if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.*
***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for patient under the age of eighteen.*

Holy Cross Hospital

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

* L G L . X . P H I *

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