Rex Healthcare
4420 Lake Boone Trail
Health Information Management
Raleigh, North Carolina 27607
919-784-3158; Fax 919-784-3343

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize:

✓	~~Rex~~ **Healthcare**

OR

	Other:
	Phone: **Fax:**

To use or disclose to:

Name: Unisource Discovery City: Signal Hill

Address: 2250 Obispo Avenue, Suite 105 State: CA Zip: 90755

Phone: 888-242-0112 Fax: 888-561-0040

the protected health information of:

Patient Name: William Vinton Date of Birth: *(Required)* 6/21/37

☐ Check here if same as above

Address: City: State:

☐ Check here if same as above

Telephone: ( ) SS#: *(voluntary)* Zip:

MR #: (HIM will complete) 1084149 Mother's Maiden Name:

Treatment Dates / Type of Service: 2/20/07-2/24/07

Information to be disclosed (please check (√) information requested):

	Face Sheet		Discharge Summary		History and Physical
	Consultations		Physician Orders		Emergency Dept. Notes
	Medication/Graphic Sheets		Progress Notes		Operative/Procedure Notes
	Pathology Report		Pictures		Lab Reports
	~~X~~-Ray Reports/Films		Discharge Instructions		Nurses Notes
✓	Itemized Bills/Statements	✓	Other: Entire Visit		

I ~~acknowledge~~ that the data released **MAY INCLUDE** material that is protected by law. My **initials** in the boxes below authorize the ~~release (if applicable) of information pertaining to:~~

	Mental Health		Drugs & Alcohol		HIV / AIDS & other communicable diseases		Genetic Testing

Over

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Patient Name/MR#: ____________________

The purpose of the use or disclosure is (please check (√) appropriate box):

	Attorney/Legal		Continued Patient Care		Social Services / Disability
	Personal Use		Insurance		Other:

I understand that:

- I may revoke this Authorization at any time.
  - The revocation will not apply to information that has already been released in response to this Authorization.
  - The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.

I understand that:

- If I revoke this Authorization, I must do so in writing.
- The procedure for revoking this Authorization is to present my written revocation to the Health Information Management Department.

I also understand that:

- I may refuse to sign this Authorization.
- Rex Healthcare will **not** condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I understand a fee may be charged for copying the protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________________. If I fail to specify an expiration date of event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

____ ____________________

Signature of Patient Date

- OR -

____ ____________________

Signature of Authorized Representative Date

____ ____________________

Witness Date

Please explain the Representative's authority to act on behalf of the patient: ______________________________

____

____

Date Completed: ____________________ Completed by: ____________________
Total Pages: ________ Sent via: Mail Courier Certified Mail Fax Picked-Up
Fax Number: ____________________ ❑ Fax # Verfied ❑ I.D. Checked: