Carroll Hospital Center, Inc. Group Welfare Plan

Authorization to Use and Disclose Protected Health Information

General Information	Associate Name:_____ Associate #:_____ Dependent Name (if applicable):_____ DOB:_____
Release Information	I, _____, hereby authorize the use or disclosure of my individually identifiable health information as described below. 1. Name(s) of organization(s), person(s), or class of persons authorized to use or disclose the information:_____ 2. Name(s) of organization(s), person(s), or class of persons who may receive and use the information:_____ 3. Description of the health information that may be used or disclosed. (Please indicate the types of records that may be release – ie., clinical summaries, laboratory reports, nurses notes, or all medical records.):_____ _____ _____ 4. The information will be used for the following purposes (all purposes must be listed): _____ _____
Associate Certification	I understand that this Authorization is voluntary and that I may refuse to sign the authorization. My refusal to sign this Authorization will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits unless allowed by law. The person/organization authorized to use and/or disclose the information will receive compensation for doing so: Yes_____ No_____ I understand that I may inspect or copy the information being used or disclosed. I understand that the information I authorize a person on entity to receive may be re-disclosed and no longer be protected by federal privacy regulations. I understand that I may revoke this Authorization at any time by notifying the person/organization providing this information in writing, except to the extent that action has been taken in reliance to this Authorization. This Authorization expires on _____[Insert applicable date/event], if no date/event is specified, 90 days after it is signed. _____ _____ Signature of Associate or Associate's Representative Date _____ Printed Name of Associate or Associate's Representative _____ Relationship to Associate or Representative's authority to act for Associate