Gibson General HOSPITAL

PHI released at time of signature ☐

PATIENT ACCOUNT #_____

Authorization For The Use or Disclosure of Health Information

By signing below, I hereby authorize Gibson General Hospital to use or disclose the following health information:
Specific Date of treatment: _____

❑ Emergency Department	❑ Inpatient	❑ Outpatient	❑ Physician Office	❑ Same Day Surgery

❑ All Health Information	❑ Alcohol & Drug Results	❑ Consultation
❑ Discharge Summary	❑ Emergency Treatment	❑ Facesheet
❑ Hepatitis Test Results	❑ History & Physical	❑ HIV Test Results
❑ Operative Report	❑ Outpatient Test Results	❑ STD Test Results
❑ X-ray Report	❑ X-Ray Images	
❑ Other (Specify)		

I hereby authorize: **Gibson General Hospital**

To release to: _____

_____

The above information is be used or disclose for the following purposes only (check one);
- ❑ _____
- ❑ **At My Request**

I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if:
- **Gibson General Hospital has taken action in reliance upon this authorization:**
- **Or, If this Authorization was given as condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.**

I understand that I may revoke this Authorization by requesting a written revocation of authorization that can be obtained by calling/writing: **Gibson General Hospital, 1808 Sherman Drive, Princeton IN 47670 - Phone Number (812) 385-9232.**

I understand that Gibson General Hospital will not condition treatment, payment, and enrollment in the health plan or eligibility for benefits on me providing this Authorization to Gibson General Hospital.

I understand that my Protected Health Information that is used or disclosed under this authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer by protected by the law.

This Authorization shall expire (check one):
- ❑ **Sixty (60) days from the date of signature (if for release of records to self); or**
- ❑ **Sooner by my choice, in which case the Authorization will expire on:** _____ **; or**
- ❑ **(Specify)** _____

By signing this authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____ _____
Signature (Patient) **Date** **Date of Birth**

_____ _____
Printed Name (Please Print Legibly) **Signature (Authorized Representative)**

_____ _____
Address **Relationship to Patient**

_____ _____
City, State, Zip Code **Witness**