

**MADISON PARISH HOSPITAL AND MPH RURAL HEALTH CLINIC
AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION**

Revocation
Date Revoked: _____
Initials of Privacy Official: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Disclosure for treatment dates: _____ to _____

Facility Name (please circle): Madison Parish Hospital Madison Parish Hospital Rural Health Clinic

I authorize this Facility to use or disclose my health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

<input type="checkbox"/> The entire medical record (all information)	<input type="checkbox"/> Business Office File
<input type="checkbox"/> Activity documentation	<input type="checkbox"/> Nursing documentation/progress notes
<input type="checkbox"/> Assessments, flow sheets	<input type="checkbox"/> Nutritional services documentation
<input type="checkbox"/> Physician's orders	<input type="checkbox"/> Physician and professional consult progress notes
<input type="checkbox"/> Care Plan	<input type="checkbox"/> Rehabilitative and restorative therapy documentation
<input type="checkbox"/> History and physical	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Social Services documentation	<input type="checkbox"/> Emergency Department Record
<input type="checkbox"/> Medication and treatment records	<input type="checkbox"/> Other: (Describe as specifically as possible)
Diagnostic reports (specify) : <input type="checkbox"/> Laboratory <input type="checkbox"/> Respiratory <input type="checkbox"/> X-Ray <input type="checkbox"/> EKG	

2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: _____ Name: _____

Address: _____ Address: _____

Name: _____ Name: _____

Address: _____ Address: _____

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3. **Purpose of use/disclosure** - This information described on the previous page will be used for the following purpose(s):

____ Initiated at the request of the patient.

____ My personal records

____ Sharing with other health care providers as needed

____ Other (please describe): _____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. **For Marketing disclosures only: (Check if applicable)** _____ I understand that the Facility will receive compensation related to the use or disclosure of the requested information.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. Unless I specify differently, this authorization will expire (insert date or event):

8. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

Signature of Patient or Personal Representative

Date

Print Name

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Witness Signature

Date

Print Name

Distribution of copies: Original to patient's Medical Record, copy to patient.

CHECKLIST FOR VALID AUTHORIZATION

Patient Name: _____ **Medical Record No.** _____

Date of Birth: _____ **Disclosure for treatment dates** _____

When you receive a request for release of Medical Records containing PHI from any entity other than the patient or the patient's personal representative, and the disclosure is not for purposes of treatment, payment or health care operations or another disclosure required or permitted by the HIPAA Privacy Rule, you may not release those records unless the requestor has provided a valid authorization. Use this checklist to assure that the authorization is valid. **If any one element is missing, the Privacy Rule prohibits you from disclosing the information.** You should contact the requestor and explain why you cannot disclose the information.

_____ The authorization must be written in plain language.

All of the following elements must be included in the authorization:

_____ A specific and meaningful description of the information to be disclosed.

_____ The name or other specific identification of the person (or organization or class of persons) authorized to make the requested disclosure.

_____ The name or other specific identification of the person (or organization or class of persons) to whom the information will be disclosed.

_____ The purpose of the requested disclosure. (If the patient initiates the authorization, the statement "at the request of the patient" is a sufficient description of the purpose).

_____ An expiration date or an expiration event that relates to the patient or the purpose of the disclosure.

_____ Signature of the patient or personal representative and date.

_____ If signed by personal representative, a description of the representative's authority to act for the patient.

Required Statements:

_____ A statement that information disclosed pursuant to the authorization may be subject to redisclosure and may no longer be protected by the Privacy Rule.

_____ A statement of the patient's right to revoke the authorization in writing and either,

_____ A reference to the revocation right and procedures described in the Notice of Privacy Practices;

OR

_____ A statement about the exceptions to the right to revoke and a description of how the patient may revoke.

_____ One of the following statements, or a substantially similar statement:

- If the Covered Entity is not permitted to condition treatment or payment on the provision of an authorization: I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

OR

- If the Covered Entity is permitted to condition the provision of research-related treatment on the provision of an authorization: I understand that the Facility will not provide research-related treatment to me unless I provide this authorization.

OR

- If the Covered Entity is permitted to condition the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party on the provision of an authorization: I understand that the Facility will not provide health care that is solely for the purpose of creating PHI for disclosure to a *third party* to me unless I provide this authorization.

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Defective Authorizations

If an authorization has any one of the following defects, it is invalid and any use or disclosure made pursuant to the authorization will be in violation of the Privacy Rule:

_____ The authorization has expired.

_____ One of the required elements or statements is missing.

_____ The Facility has knowledge that the authorization has been revoked.

_____ The authorization violates the regulations governing conditioning treatment or payment upon signing the authorization, or combining authorizations.

_____ The Facility has knowledge that information in the authorization is false.

Hospital or Clinic Representative Signature

Date