NASH HOSPITALS, INC.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, hereby authorize Nash Hospitals, Inc. to disclose the following information from the health records of:
(Print the name of person authorized to make requested disclosure)

Patient Name: _____ Date of Birth: _____

Address: _____ Social Sec. #: _____

_____ Telephone: _____

RELEASE TO: _____
Name of Facility/Person

_____
Address

_____
City, State, Zip Code

Attn: _____

Fax#: _____

Information to be disclosed:

- ☐ Complete Health Record(s)
- ☐ History & Physical Examination
- ☐ Consultation Reports
- ☐ X-Ray Reports
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ Other (please specify) _____

Dates to be disclosed: from _____ to _____

I understand that the requested information may include, if applicable, information relating to: Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) Infection, Sexually Transmitted Diseases (STD's), Psychiatric and/or Behavioral Care, and Treatment for Alcohol and/or Drug Abuse.

This information is to be for the purpose(s) of _____.

I understand that this request for release of information is effective for 90 days and that once disclosed the information released is subject to redisclosure by the recipient and possibly no longer protected by the federal privacy laws. This request may be revoked at any time by a written request to the Health Information Management Department, but such request will not be retroactive for requests that have already been complied with. I understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and Nash Hospitals, Inc. will not condition my treatment on whether I sign it. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I have questions about disclosure of my health information, I can contact the Heath Information Management Department.

I request the information to be released to me in the following format: _____paper _____electronically (3 business days).

I agree to any and all charges for the above mentioned health information.

SIGNED: _____OR
Signature of Patient Date Telephone

SIGNED: _____
Signature of Personal Representative Date Telephone