SageWest HEALTH CARE

For Office Use Only

Verified: Yes / No
By: _____
D. Lic. #: _____
SS #: _____
Signature: Yes / No

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____Date of Birth: _____Phone: _____

I hereby authorize **SageWest Health Care** to use/disclose my individually identifiable health information in the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorized by this document is not a health plan or health-care provider, that my information may no longer be protected from further disclosure by state or federal law.

Dates of Service/Encounter to be released: _____
List the specific information that is authorized for disclosure:

☐ ER Record	☐ Consultation	☐ Discharge Summary	☐ EKG's	☐ Pathology
☐ Emergency	☐ Radiology	☐ Laboratory	☐ Entire Record	☐ Itemized Bill
☐ History/Phys	☐ Op Report	☐ Face Sheet	☐ _____	☐ _____

Enter the name/address/city/state/zip code and phone number of which the information can be released: _____
_____
_____

☐ Mail ☐ Pick Up ☐ Email _____ ☐ Fax _____ ☐ Other _____

Purpose of disclosure: _____
_____

(Patient must read and complete information in this section)

- I understand that this authorization will expire ***1 YEAR*** from today's date unless specified otherwise ___ /____ / ____.++
- I understand that I may revoke this authorization at any time by notifying SageWest Health Care in writing, except to the extent that has already taken in reliance of the previous authorization period.
- I understand that I have the right to receive a copy of this information if I request it.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that unless restricted by individual state laws, that this information may contain information about HIV, AIDS, venereal disease, or mental health disorders. I understand, that the exception to this authorization applied to (in accordance with 42 CFR part 2) records containing drug/alcohol abuse or therapist psychiatric notes. These record types require a separate authorization.

_____

Signature of Patient or Patient's Representative **Date****

****This authorization is valid for one (1) year from the date of signature, unless the expiration date is entered++. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation.***

If not signed by patient please indicate relationship: ❑ Parent or guardian of minor patient ❑ Guardian or conservator of incompetent patient ❑ Beneficiary or representative of deceased patient

_____ FAX OR EMAIL COPY OF PHOTO ID WITH THIS AUTHORIZATION Release prepared by: _____