PROVIDENCE HOSPITAL

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

1. I authorize *Providence Hospital to disclose the following information from the health records of:
   Patient Name: _____
   Date of Birth: _____
   Telephone Number: _____
   Address: _____
2. Please provide the date(s) that the service(s) was provided:_____
3. Please mark the desired information to be sent:

☐ Face sheet	☐ Operative Reports	☐ Mental health
☐ History and Physical	☐ Consultation Reports	☐ Substance Abuse
☐ Laboratory/Pathology Records	☐ HIV Records	☐ Office Progress Notes
☐ Discharge Summary	☐ X-Ray Films/Radiology Records	
☐ Complete Record	☐ Emergency Department Record	

   Other: _____
4. Please send the records that I marked above to (use additional sheets if necessary):
   Name: _____
   Address: _____
   Telephone: _____ Fax: _____
5. Purpose of disclosure: _____
6. Unless otherwise indicated this authorization will expire in 60 days by DC law. _____
7. ☐ I do ☐ I do not
   Authorize release of information related to psychological or psychiatric impairment, substance abuse, alcoholism, Acquired Immunodeficiency Syndrome (AIDS), test for Human Immunodeficiency Virus (HIV), sexually transmitted diseases, sexual assault and criminal cases and photographs.
8. Unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978 (the "Mental Health Act"). Disclosure may only be made pursuant to an express written authorization signed by the patient as provided in the Act. Civil and criminal penalties may be assessed for violations. Under the Mental health Act you have a right to inspect your mental health information.
9. I understand that after my protected health information is disclosed, it may no longer be protected by privacy laws.
10. I understand that this authorization is voluntary and I may refuse to sign it. My refusal to sign will not affect my ability to obtain treatment, receive payment or to become eligible for benefits unless allowed by law. You have the right to revoke this authorization only by writing to the Health Information Management Department at Providence Hospital. You may revoke this authorization at any time except to the extent that action has been taken or is required by law.
11. I understand there may be a charge to obtain my medical records.

_____ _____

Signature of Patient or Patient's Authorized Representative Date/Time

_____

Print name of Personal Representative Relationship

*Providence Hospital includes Carroll Manor, Seton House, Ft. Lincoln Family Medical Center, Perry Family Health Center and Providence Physician Enterprise.