AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ________________________________ **Date of Birth:** ______________ **Email:** ________________________________

Medical Record#: _____________________________ **Social Security #:** _______________ **Phone:** ________________________________

Mailing Address:____

I authorize Howard University Hospital and it's entities to disclose protected health information about the above listed to:

Name: ____

Address: ____

City: ________________________ **State:** ___________ **Zip Code:** _________ **Phone:** ______________

Phone: ____ **Fax:** ____

Records are requested for the purpose of:

☐ **Continuing care/Medical Facility** ☐ **Legal** ☐ **Personal Use** ☐**Insurance** ☐**Other:**____________________

Documentation can be released electronically if stored in an electronic media. ***Please check with Howard University Hospital medical records department to determine if your health information is available for electronic release.***

The specific information to be disclosed is:

☐ **Record Abstract** ☐**Nurses Notes** ☐**Consultation Reports** ☐**H&P Exam** ☐**Allergies**

☐ **Discharge Summary** ☐**Discharge Instructions** ☐**Emergency Department Record** ☐**Problem List**

☐ **Operative Report** ☐**Pathology Report** ☐**Physical Therapy Records** ☐**Physician Orders**

☐ **Diagnostic Tests** ☐**Medication Lists** ☐**Complete Health Record** ☐**Other:**______________________________

From: _____________________________To: ___________________________
(Date range of records needed from) (Date range of records needed to)

Please select one of the following: ☐**Paper Copy** ☐**Electronic Media**

I acknowledge that the information dislosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV); sexually transmitted diseases, tuberculosis or genetics. **IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL. DO NOT RELEASE ______________________.**

I have the right to revoke this authorization by written notice to this facility. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on ___________________ or upon the following event: ______________________.

If no date is specified, this authorization will expire in six months from the date of signature below.

Patient Signature: ____ **Date:**__________________

Signature of Authorized Representative: ____ **Date:**__________________

If signed by a personal representative, a description of the representative's authority to act is as follows:

☐**Parent or Legal Guardian** ☐**Power of Attorney** ☐**Next of Kin Deceased** ☐**Executor of Estate**

Please be aware that health care facilities are authorized by the District of Columbia & Government regulations to charge for the reproduction of medical records and that charges may be associated with the request. Requestors may be notified in advance of the amount due for the request and records will be sent upon the receipt of payment.

Contact information for the Health Information Management Department (Medical Records):

Howard University Hospital
Medical Records Correspondence
2041 Georgia Avenue, N.W.
Room 2038 A
Washington, DC 20060

Phone: 202-865-1551
Fax: 202-865-7968
www.huhhealthcare.com