Southeast HEALTH

SOUTHEAST HEALTH AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of patient (Printed) | Previous Names (if applicable)

Date of Birth | Daytime telephone number

Send Information to: (please be specific)

Southeast Health
Provider Name/Organization

1701 Lacey Street
Address | Phone Number

Cape Girardeau, MO 63701
City, State, Zip | Fax Number

Information to be Released From: (please be specific)

Provider Name/Organization

Address | Phone Number

City, State, Zip | Fax Number

Purpose of Disclosure:

[ ] Transfer of Care
[ ] Self
[ ] Specialist
[ ] Other (must complete) _____

PSYCHIATRIC UNIT ONLY
[ ] Family/Friend Inquiry
Family/Friend's Name: _____

Information to be Disclosed:

Date of Service: _____

[ ] Medical Records from the last two years
[ ] Summary Health Information
[ ] Complete Designated Record Set
[ ] Billing Claim Form
[ ] Detailed Billing Statement

PSYCHIATRIC UNIT ONLY
[ ] Patient Presence on Unit
[ ] Condition Report
[ ] Patient Phone Number

[ ] Other: _____ [ ] Expiration Date (or event): _____

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 180 days of receipt, and may be revoked at any time, provided the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re−diclosure and may no longer be protected by the HIPAA of 1996.

Signature of Patient or Representative | Relationship to Patient | Date

Disclosures Requireing Special Consent:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for
[ ] HIV / AIDS virus [ ] Sexually Transmitted Diseases
[ ] Mental Health / Psychiatric Disorders [ ] Drug, Alcohol Abuse / Treatment

Signature of Patient or Representative | Relationship to Patient | Date

For Facility Use:
Date Received: _____ Medical Record Number: _____ Date Information Release: _____
Person/Department Sending Records: _____