AUTHORIZATION FOR RELEASE OF INFORMATION

Individual: (name and information of the person whose protected health information is being disclosed)

Patient Name (LAST, FIRST, MIDDLE): ______________________________

Date of Birth: ____________ Phone#: ____________ Email: ____________________

Address: ______________________ City: ____________ State: ______ Zip: ________

Authorization and Purpose - I authorize Shannon to release my health information records to the following:

☐ Self

☐ ______________________________

Person /Organization/ Healthcare Provider authorized to receive my records:

____

Address (City, State, Zip)

____

Contact Name Phone # Fax#

____

Relationship to me

Patient information is needed for: (Please select one option)

☐ Continuing Medical Care ☐ Military ☐ Personal Use ☐ School ☐ Insurance

☐ Legal Purposes ☐ Social Security Disability ☐ Upcoming Appt (list date): ____________________

Specific Description of Information to be Used or Disclosed: (Please note this section CAN NOT be used to release Psychotherapy Notes)

Dates of treatment (date range) from: __________to ____________ ☐ Hospital ☐ Clinic

Substance Use Disorder Records

☐ **I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records**

☐ **I authorize the release of the following information excluding all records that include any substance use disorder and/or substance use disorder treatment records**

Only the information and records indicated below (check all that apply):

☐ Physician Office Visits ☐ History/Physical Exam ☐ Lab Results ☐ Discharge Summary ☐ Shot Record

☐ Operation Reports ☐ Consultation Reports ☐ Radiology Images ☐ Radiology Reports ☐ Pathology Reports

☐ Discharge Instructions ☐ ER Report ☐ After Visit Summary ☐ Entire Record

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED

☐ Paper ☐ CD ☐ My Chart ☐ Pick Up ☐ Mail

☐ Email (Encrypted through ShareFile) to the email address above

FOR OFFICE USE ONLY:

ID Confirmed: ____________________

ID Type / ID#

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Expiration, Right to Revoke, and Re-Disclosure Acknowledgement:

Expiration: This authorization will expire one year from the date of signature for the recipient and date range listed above:

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this page. I understand that revocation of this authorization will not affect any action Shannon Health took in reliance on this authorization before Shannon Health received my written notice of revocation.

Re-Disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Fee for Providing Requested Information: I understand that there may be a fee charged for the copying of the requested information. I have been notified of this policy and agree to pay accordingly.

Signature of Patient or Personal Representative with Authorization to Request Disclosure (this document must be signed by the individual, parent of a minor child, or legal guardian): I understand that Shannon may not condition treatment, payment, enrollment, or eligibility for benefits (including financial assistance) on my provision of this authorization. I can view or receive a copy of the protected health information to be used or disclosed.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information to be released may include, but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

____

Signature of Patient or Legally Authorized Representative — Date

____

Printed Name of Patient or Legally Authorized Representative — Relationship to Patient

MAKE A PHOTOCOPY OF THIS SIGNED AUTHORIZATION BEFORE SENDING.

RETURN COMPLETED, SIGNED AUTHORIZATION TO:

Preferred Method, Return via E-Mail
ROIRequests@shannonhealth.org

Mailing Address
Shannon Health System
HIM/Release of Information
120 E. Harris Avenue
San Angelo, Texas 76903

Physical Address
Shannon Health System
HIM/Release of Information
3555 Knickerbocker Road
San Angelo, Texas 76904