SHANNON

AUTHORIZATION FOR RELEASE OF INFORMATION

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

Patient Name (LAST, FIRST, MIDDLE): _____

Date of Birth: _____ Phone#: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

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

_____

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): _____

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

Dates of treatment (date range) from: _____to _____ ☐ Hospital ☐ Clinic

☐ 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 email address above

FOR OFFICE USE ONLY:

ID Confirmed: _____
ID Type / ID#

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

Expiration: This authorization will expire one year from 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.

VI. 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.

VII. Signature of Patient or Personal Representative with Authorization to Request Disclosure (this document must be signed by the individual, parent of minor child, 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