ally MEDICAL EMERGENCY ROOM

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize **Ally Medical Emergency Room** to use or disclose information from the medical record of:

PATIENT NAME		MEDICAL RECORD #	
DATE OF BIRTH		DATE(S) OF SERVICE	

I understand that this medical record may include information regarding sexually transmitted diseases, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral/mental health services, or treatment for alcohol/drug abuse.

I understand that I have the right to revoke this authorization at any time but must do so in writing and present a written revocation to the individual or organization releasing the information. I understand that a revocation will not apply to information already released in response to this authorization, nor will it apply to an insurance company when the law provided the insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or 180 days following the date this request is signed.

I understand that authorizing the disclosure of health information is voluntary and that I can refuse to sign this authorization. I do not need to sign this authorization to receive medical treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can call **(512) 451-0911.**

I understand that this medical record may contain reports, test results, and notes that only a physician can interpret. I understand that I should contact my physician regarding the entries made in this medical record to prevent misunderstanding of the information contained in these entries. I will not hold Ally Medical Emergency Room liable for any misinterpretation of the information in this medical record due to not consulting my physician for a correct interpretation.

Records to be provided to ____ *(name of individual or entity) via:*

MAIL		FAX	

Records requested:

- ☐ **Full medical record** *(nurse & provider charting including lab and radiology reports)*
- ☐ **Registration documents** *(scanned images with clinical elements removed)*
- ☐ **Discharge instructions**
- ☐ **Lab & Radiology reports**
- ☐ **Radiology images** *(radiology images on CD)*
- ☐ **Work/School excuse**
- ☐ **Partial medical record** *(exclude the following information ____)*
- ☐ **Wearable cardiac monitor report** *(to be printed by FA)*

For the purpose of: ____

- ☐ Continued patient care
- ☐ Attorney/Legal
- ☐ Social Security/Disability
- ☐ Personal
- ☐ Worker's compensation
- ☐ Insurance

______________________________ ______________________________

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE

______________________________ ______________________________

RELATIONSHIP TO PATIENT WITNESS

ally MEDICAL EMERGENCY ROOM

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(STAFF DOCUMENTATION)

Identification presented: *(requires only 1)*

- [ ] DRIVER'S LICENSE
- [ ] PASSPORT
- [ ] OTHER IDENTIFICATION CARD ______________________________

Identification NOT presented but verified by ALL of the following:

- [ ] NAME
- [ ] DATE OF BIRTH
- [ ] ADDRESS
- [ ] PHONE NUMBER

Records released to: ______________________________ *(name or entity)*

PRINT	*(# of pages)*	MAIL	
FAX			
		EMAIL	

______________________________ ______________________________
ALLY MEDICAL REPRESENTATIVE DATE