Entire medical record  HIV/AIDS test results and treatment  Progress notes  Lab results  Mental or behavioral health records  Photographs, videotapes, or other images  Treatment plan  Alchol and drug treatment records  Summary of treatment  X-ray reports  Genetic test results  Consultation reports  Admission notes  Psychotherapy notes  History and physical exam  Discharge summary  The following billing and payment information:  Other (specify):  1. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Facility. However, the revocation will not average any effect on any uses or disclosures the Facility may have made before the revocation was received.  2. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the late this authorization that unless I revoke the authorization earlier, this authorization may no longer be protected by federal law, an obtained by the receiving party.  Refusal to Sign. I understand that i may refuse to sign this Authorization and that the Facility will not condition treatment on whether I sign this unthorization. Certify that I am (check whichever applies):  The patient and the identification that I have provided is true and correct.  The patient and the identification that I have provided is true and correct.  The patient and the identification that I have provided is true and correct.  The patient suthorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of:  Signed this day of		MR#	ACCT#
Patient Account Number   Patient Account Number   Date of Birth   State 2p   Social Security Number   Outco of Death	I,, hereby aut		
Patient Phone Number    Date of Death	Patient Name Patient Address	Date of Birth	
Recipient Name   Address   City, State, Zip	Patient Phone Number	Date of Death	^^^^
The purpose of the use of this disclosure is:   At the request of the patient: or   Other (specify):	Recipient Name		Chata Tin
If the purpose is for marketing, will the facility receive direct or indirect compensation or payment in return for using or disclosing the patient's health information.   Yes   Not payment   Not		City,	State, ZIP
Entire medical record   HIV/AIDS test results and treatment   Progress notes	If the purpose is for marketing, will the facility information? YES NO	receive direct or indirect compensation or payment in re	
Lab results	following dates (insert dates):		
Treatment plan Alcohol and drug treatment records Summary of treatment A-ray reports Genetic test results Consultation reports Admission notes Psychotherapy notes Discharge summary The following billing and payment information:  Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Facility. However, the revocation will not aver any effect on any uses or disclosures the Facility may have made before the revocation was received. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar monits after the late this authorization is signed. Seedisclosure. I understand that I may refuse to sign this Authorization and that the Facility will not condition treatment on whether I sign this authorization. Seedisclosed by the receiving party. Sefusal to Sign. I understand that I may refuse to sign this Authorization and that the Facility will not condition treatment on whether I sign this authorization. Certification. I certify that I am (check whichever applies): The patient and the identification that I have provided is true and correct. The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of:  Signed this day of			
X-ray reports   Genetic test results   Consultation reports			
Admission notes    Discharge summary   The following billing and payment Information:			
Discharge summary  Other (specify):    Revocation.   understand that   may revoke this authorization at any time by sending a written notice to the Facility. However, the revocation will not have any effect on any uses or disclosures the Facility may have made before the revocation was received.   Expiration.   understand that unless   revoke the authorization earlier, this authorization will automatically expire six (6) calendar monits after the late this authorization is signed.   Redisclosure.   understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, an obudic be re-disclosed by the receiving party.   Refusal to Sign.   understand that   may refuse to sign this Authorization and that the Facility will not condition treatment on whether   sign this Authorization.   Certification.   certify that   am (check whichever applies):   The patient and the identification that   have provided is true and correct.   The patient and the identification that   have provided is true and correct.   The patient's authorized representative, and that the identification and proof of authority that   have provided are true and correct. My relationship to the patient is that of.   Signature of person completing form:   Printed Name:   Printed Name:   Date:   /       Printed Name:   Date:   /   /     Printed Name:   Printed Name:   Date:   /   /			
Other (specify):    Revocation.   understand that I may revoke this authorization at any time by sending a written notice to the Facility. However, the revocation will not have any effect on any uses or disclosures the Facility may have made before the revocation was received.   Expiration.   understand that unless   revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the late this authorization is signed.   Re-disclosure.   understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, an obudic be re-disclosed by the receiving party.   Refusal to Sign.   understand that I may refuse to sign this Authorization and that the Facility will not condition treatment on whether I sign this Authorization.   Certification.   certify that   am (check whichever applies):   The patient and the identification that I have provided is true and correct.   The patient and the identification that I have provided is true and correct.   The patient is unthorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of:    Signature of person completing form:			History and physical exam
Nevocation   I understand that I may revoke this authorization at any time by sending a written notice to the Facility. However, the revocation will not have any effect on any uses or disclosures the Facility may have made before the revocation was received.		The terror is a series of the purification in the series of the series o	
Signature of person completing form:  Printed Name:  Address (if different from above):  Phone (if different from above):  Witness:  Printed Name:  For Facility Use Only:	Tave any effect on any uses or disclosures the F2. Expiration. I understand that unless I revoke date this authorization is signed.  3. Re-disclosure. I understand that information could be re-disclosed by the receiving party.  4. Refusal to Sign. I understand that I may refus Authorization.  5. Certification. I certify that I am (check whiche The patient and the identification that I The patient's authorized representative relationship to the patient is that of:	racility may have made before the revocation was rece the authorization earlier, this authorization will automat used or disclosed in accordance with this authorization se to sign this Authorization and that the Facility will no over applies): have provided is true and correct. e, and that the identification and proof of authority that	ived. ically expire six (6) calendar months after the may no longer be protected by federal law, and t condition treatment on whether I sign this
Phone (if different from above):  Witness:  Printed Name:  For Facility Use Only:	Signature of person completing form:		Date:/
Witness:  Printed Name:  For Facility Use Only:	Address (if different from above):		
Printed Name:  For Facility Use Only:			
			Date://
	For Eacility Hea Only		
Date Received:			

Copy made?□Yes □No

Copy made?□Yes □No

How was identity verified?

How was authority verified?

Title

Name of person accepting form: