HealthMark

AUTHORIZATION FOR RELEASE OF OUTGOING MEDICAL INFORMATION

____ (Print **patient's** full name)	_______________________________ Birth date (Mo/Day/Yr)
____ (Street address)	_______________________________ Social Security Number
____ (City, state, zip code)	_______________________________ Phone (Home)
____ (Previous name, if different from above)	_______________________________ Phone (Work or Cell)

At the request of the individual, I _________________________, do hereby authorize **HealthMark**
(Patient's name)

to release:

_____DISCHARGE SUMMARY	______PATHOLOGY REPORTS	_______EMERGENCY REPORTS
_____HISTORY & PHYSICAL	______LABORATORY REPORTS	_______OTHER___________________________________
_____PROGRESS NOTES	______RADIOLOGY REPORTS	___________________________________
_____OPERATIVE NOTES	______ECG/EEG/CARDIC CATH	___________________________________

_____ I do ____ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

____Name of Company/Agency/Facility/Person
____Street address
____City, state, zip
Phone_____________________ Fax___________________

REASON FOR RECORDS REQUEST: ____Referral, ____Insurance, ____Workers Comp, ____Legal investigation ____Disability Determination, ____Change of Doctor (if change of doctor please state why?) ____

____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for __ months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____________________________ Date:___________	**______________________Date:___________**
Signature of individual (or Guardian or Personal Representative of patient's estate)	Reviewed by: Name of Employee

NOTE: THERE WILL BE A CHARGE FOR A PERSONAL COPY. SMART CORPORATION HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. THERE IS NO CHARGE IF THE PERMANENT TRANSFER IS SENT DIRECTLY TO THE PHYSICIAN'S OFFICE TO WHICH YOU ARE TRANSFERRING.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE_______	LAB________	EKG___________	____
DS__________	EKG________	IMMUNE_______	ROI SPECIALIST
OP__________	X-Ray_______	OTHER_______________________	____
HP__________	PATH_______	____________________________	DATE