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| **Patient Information** |
| PATIENT NAME       |   |
| ADDRESS       |   |
| CITY/STATE/ZIP       | PHONE NUMBER       |
| DATE OF BIRTH    /    /      | HOSPITAL NAME       |

**I authorize Healogics to use or disclose protected health information as described below**

|  |  |  |
| --- | --- | --- |
| **Information About Who Is Authorized to Receive Patient’s Information** |  | **Purpose of the Use/Disclosure** **(Check at least one)** |
| NAME       |  | [ ]  | INSURANCE |
| ADDRESS 1       |  | [ ]  | ATTORNEY |
| ADDRESS 2       |  | [ ]  | AT THE REQUEST OF THE INDIVIDUAL |
| CITY, STATE, ZIP       |  | [ ]  | OTHER (SPECIFY) |
| PHONE NO.       |  | [ ]  |  |
| EMAIL ADDRESS (if electronic disclosure)       |  |

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| **Description of Information Authorized to Be Used/Disclosed****(Check all that apply)** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ]  | Complete Record | [ ]  | Laboratory Reports | [ ]  | Progress Notes |
| [ ]  | Record Summary | [ ]  | Imaging Reports (like x-rays, CTs, MRIs) | [ ]  | Nursing Information |
| [ ]  | Discharge Summary | [ ]  | Pathology Reports | [ ]  | Billing Records |
| [ ]  | Physician Orders | [ ]  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  | Medication Records |
|  |  |
| **Date Range of Information to Be Used/Disclosed** | [ ]  All Dates of Service |
| [ ]  Specific Date Range |
| Start Date    /    /    | End date    /    /    |

**By signing this authorization, I agree to the following:**

* I understand if I authorize protected health information to be released to a party not subject to federal privacy laws, it is possible the information may be re-disclosed by the recipient and the information may no longer be protected under privacy laws.
* I understand that authorizing the use and/or disclosure of this health information is voluntary and that I am not required to sign this authorization. I understand I do not need to sign this form in order to receive treatment.
* I understand that I can revoke this authorization in writing at any time by contacting the wound care center where I (the patient) received care, but revoking this authorization does not affect any circumstance where Healogics has acted in reliance of this authorization.
* I understand that if I request an electronic copy of my medical records and the information is given to me on unencrypted media (such as a flash drive or CD), I should protect the media, because the information is not protected from being accessed if it is lost or stolen.
* This authorization expires six months from the date on which it was signed, unless otherwise specified. (Otherwise specified date, event, or condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Signature of Patient or Personal Representative |  | Date |  |  |
|  |  |  |  |  |
| If not signed by patient, list personal representative’s authority to act for the patient |  |  |  |  |

***A copy of this authorization must be provided to the patient/personal representative.***