



HARDIN COUNTY REGIONAL HEALTH CENTER

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ DOB _____

Receipt of Privacy Practices:

____ I hereby acknowledge that I was provided with Hardin County Regional Health Center's Notice of Privacy Practices.

Release of Information Authorization:

____ I do not wish my Protected Health Information released to anyone.

____ I hereby authorize the office of Hardin County Regional Health Center to release my Protected Health Information to the following individuals:

Table with 3 columns: Name, Relationship, Telephone

NOTE: A separate release of medical records is required for all psychotherapy notes.

Contact Preferences:

I wish HCRHC to adhere to the following contact preferences:

Home Phone:

- Ok to leave detailed information
Leave only a call back number

Written Communication:

- Ok to send information to my home address
Do not send anything to my work address
Ok to send anything to my work address
Only send mail to the following address:

Work Phone:

- Ok to leave detailed information
Leave only a call back number

Consent for Treatment: Please check all that apply

- I consent to receive treatment by the providers of Hardin County Regional Health Center.
I hereby consent to allow treatment of my child if brought to Hardin County Regional Health by the following individuals:

Table with 3 columns: Name, Relationship, Telephone

NOTE: Please add these persons to the Release of Information section of this document IF the provider can discuss treatment

I attest that I have the legal authority to enter into this agreement and that I may update this authorization at any time by completing a new form.

Pt. Signature _____ Date _____

HCRHC USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Authorization to Release Protected Health Information, but could not be obtained for the following reasons:

- Individual refused to sign
Communication barriers prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgment
Other (Please specify) _____

Staff representative signature _____ Date _____

