SAMARITAN HOSPITAL

PATIENT HEALTH INFORMATION AUTHORIZATION AND ACCESS

Patient Information (Please Print)

First Name | Middle Initial | Last Name

Name at time of treatment | Date of Birth (mm/dd/yyyy)

Phone Number | Email

Street | City/State | Zip Code

I give special permission to release any information regarding (initial applicable lines below):

____Substance Abuse ____Psychiatric/Mental Health Info ____HIV Info ____STDs ____Physical Abuse/Assault

Other: _____

How would you like to receive your records:

____Paper - Please contact Medical Records after each visit to obtain copies of records.

____Patient Portal Access _____ Decline Patient Portal Access

Samaritan Hospital should provide records to: ☐ SELF ☐ Personal Representative (indicated below)

Recipient Name | Recipient Phone Number

Recipient Address | Recipient Email

____The client's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the client's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, e.g., a power of attorney or probate court order.

This authorization will expire one(1) year from the date of my signature below.

I authorize the following_____to be given copies of medical records and/or access records via patient portal.

Patient or Personal Representative - Please Print | Relationship to Patient

Signature of Patient or Personal Representative | Date/Time

Samaritan Hospital recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing and producing requested records.

!2AUTH!