Tri-State
MEMORIAL HOSPITAL &
MEDICAL CAMPUS

TRI-STATE MEMORIAL HOSPTIAL
Perpetual Authorization to Disclose Health Care Information

Patient name: _____

Date of birth: _____ Previous name: _____

I. I authorize TSMH and clinics to leave messages for the above named patient on telephone number (s) _____

II. I authorize TSMH and/or the following clinic: _____

_____

to disclose my health care information to the individual listed below who may inquire on my behalf about medical issues.

_____

Name (print)

_____

Address City State/Zip

(____)_____

Telephone number Relationship

You may disclose the following health care information (check all that applies):

- □ All health care information in my medical record (see next section to release protected health information)
- □ Related to the following treatment or condition: _____
- □ For the date(s) of: _____
- □ Other (e.g., x-rays, bills) specify date (s): _____

You may disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- □ HIV (AIDS virus)
- □ Sexually transmitted diseases
- □ Psychiatric disorders/mental health
- □ Drug and/or alcohol use
- □ Reproductive Health – ***only for minors under 18 years of age***

This authorization shall continue in perpetuity from the date signed or until my 18th birthday unless revoked as below.

III. My Rights

I understand I may revoke this authorization in writing to the address of the office named above. If I do revoke this authorization, it will not affect any actions already taken by TSMH based upon this authorization.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of the patient Relationship

Additional individuals to disclose medical issues to:

Name (print)

Address City State/Zip

( )

Telephone number Relationship

Name (print)

Address City State/Zip

( )

Telephone number Relationship

Name (print)

Address City State/Zip

( )

Telephone number Relationship

Name (print)

Address City State/Zip

( )

Telephone number Relationship

Name (print)

Address City State/Zip

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Telephone number Relationship

Name (print)

Address City State/Zip

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Telephone number Relationship