RIVER CREST HOSPITAL

RIVER CREST HOSPITAL – 1636 HUNTERS GLEN ROAD – SAN ANGELO, TEXAS 76901 – (325) 949-5722 TOLL FREE: (800) 777-5722 FAX (325) 223-7318

HIPAA COMPLIANT CONSENT AND AUTHORIZATION TO RELEASE INFORMATION OR MEDICAL RECORDS UNDER THE PROTECTION OF FEDERAL LAW TITLE 42, CFR, CHAPTER 11, PART 11

PATIENTS NAME:_____ **SOCIAL SECURITY NUMBER**_____

D.O.B_____ **PHONE:**_____ **ADDRESS:**_____

CITY/STATE/ZIP:_____

I, _____**AUTHORIZE RIVER CREST HOSPITAL TO :**

____ **PROVIDE INFORMATION TO** ____ **REQUEST & RECEIVE INFORMATION FROM**

FACILITY/INDIVIDUAL:_____ **RELATIONSHIP TO PATIENT*:** _____

ADDRESS:_____

CITY/STATE/ZIP:_____

***This person is the emergency contact and should be contacted in an emergency situation.** ☐ **Yes** ☐ **No**

PHONE:_____ **FAX:**_____ **EMAIL:** _____

INFORMATION TO BE RELEASED:

☐ ENTIRE RECORD ☐ DISCHARGE PACKET* ☐ ******DO NOT RELEASE INFORMATION***EMERGENCY CONTACT ONLY******

☐ OTHER: _____

**Discharge Packet - Face Sheet, Medication Reconciliation, Psychiatric Evaluation, Discharge Note, Discharge Plan, Discharge Safety Plan*

INFORMATION IS TO BE USED FOR THE PURPOSE OF:

☐ EVALUATION AND TREATMENT ☐ INSURANCE ☐ PERSONAL USE ☐ CONTINUITY OF CARE ☐ OTHER: _____

☐ NOTIFICATION OF EMERGENCY ONLY

"This release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFT 160 and 164, and all federal regulations and interpretive guidelines promulgated there under"
"Once the requested PHI is disclosed, the PHI's recipient may re-disclose it, therefore the Privacy Regulations may no longer protect it."

This authorization to release information will be effective for 180 days. You may terminate this authorization, at any time, by presenting to River Crest Hospital in person and signing the appropriate form requesting termination of this authorization.

I hereby release River Crest Hospital from all legal liability that might arise from the release of the information requested. I consider a photocopy of the authorization to be as valid as the original.

I AUTHORIZED THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION REGARDING:

_____ **HIV/AIDS** (Initials) _____ **ALCOHOL/DRUG/SUBSTANCE ABUSE TREATMENT** (Initials)

× _____ **DATE** _____

PATIENT SIGNATURE*

_____ **DATE** _____

PARENT/LEGAL GUARDIAN**

_____ **DATE** _____

WITNESS

* *FOR PATIENT AGE 16 OR 17 BOTH PATIENT AND PARENT/LEGAL GUARDIAN MUST SIGN*
** *MUST PROVIDE DOCUMENTED PROOF OF LEGAL ENTITLEMENT*

I am revoking this consent effective _____ (Date) **at** _____ (Time)**. I understand that River Crest Hospital will not be responsible for information disclosed before this date.**

_____ **Patient/Guardian Signature** _____ **Witness Signature**

WHITE – CHART **YELLOW – MEDICAL RECORDS**