Form 3.2

HH Health System-Shoals, LLC d/b/a Helen Keller Hospital

Authorization to Disclose Protected Health Information

Patient Name:____________________________ Date of Birth:_______________ Unit or SS #:_________________

The following person or entity is authorized to disclose my medical records:

☐ **Helen Keller Hospital**
P.O. Box 610
Sheffield, AL 35660
Phone: (256) 386-4017
Fax: (256) 386-4687

☐ **Lauderdale EMS**
36 Wheeler St
Rogersville, AL 35652

☐ **Keller EMS**
P.O. Box 610
Sheffield, AL 35660
Phone: (256) 386-4601
Fax: (256) 386-4129

☐ **Lauderdale EMS**
310 Dr. Hicks Blvd.
Florence, AL 35630
Phone: (256) 766-4975
Fax: (256) 766-4988

☐ **N. AL Sleep Center**
1111 S Raleigh Ave. St 200
Sheffield, AL 35660
Phone: (256) 386-4191
Fax: (256) 386-4192

☐ **Red Bay Hospital**
P.O. Box 490
Red Bay, AL 35582
Phone: (256) 356-9532
Fax: (256) 356-2809

☐ **Keller HHC & Hospice**
P.O. Box 490
Red Bay, AL 35582
Phone: (256) 356-8160
Fax: (256) 356-6861

☐ **Keller Outpt Surgery Pav**
P.O. Box 610
Sheffield, Al 35630
Phone: (256) 386-5900
Fax: (256) 386-5911

☐ **Northwest Physician Practice Management LLC**
______________ __________
Physician Practice

☐ **Med Express**
14490 County Line Rd, Ste 1
Muscle Shoals, AL 35661

☐
____
____

This disclosure will be made to the following person or entity:

Address:
____
____
____

For the purpose of: At the request of the patient, OR____________________________

The type and amount of information to be used or disclosed: Dates of Care: From:_____To:_____

- ❑ **Face Sheet**
- ❑ **History/Physical**
- ❑ **Operative Report**
- ❑ **Discharge Summary**
- ❑ **Consultation Reports**
- ❑ **Emergency Room Record**
- ❑ **Pathology Report/Slides/Blocks** ***(Slides/Blocks must be returned to MR Dept.)***
- ❑ **Laboratory Results**
- ❑ **X-Ray and Imaging Reports**
- ❑ **Entire Records** **Other:**____

Copied: ___________
Initial: ___________
Date Sent: ___________

I hereby authorize the use or disclosure of information about the above named individual and I understand that:

1. This information about me is protected under federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing.
4. Any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.
5. Unless I revoke this authorization, it will expire on the following date ___/___/___, event or condition: ____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
6. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
7. Treatment or payment will not be based on my signing this authorization.
8. I will receive a copy of this information.
9. **I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.**

____
Signature of Patient or Personal Representative

____
Date

____
Relationship of Personal Representative to the Patient

____
Signature of Witness

Revised 2/2015