

<b>Patient Name:</b>	<div style="display: flex; justify-content: space-between; width: 100%;"> <span>_____</span> <span>_____</span> <span>_____</span> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>Last</span> <span>First</span> <span>Middle</span> </div>
<b>Home Address:</b>	<div style="border-bottom: 1px solid black; height: 20px;"></div>
<b>Home Telephone:</b>	<div style="border-bottom: 1px solid black; height: 20px;"></div>
<b>Date of Birth:</b>	<b>SSN:</b>
<b>Specify Information to be Disclosed:</b>	
<input type="checkbox"/> History and Physical <input type="checkbox"/> Consultation <input type="checkbox"/> Operative Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Pathology Report <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> EKG Reports <input type="checkbox"/> Electronic Copy of Medical Record <input type="checkbox"/> Other (please list): _____	
<p>By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:</p>	
<input type="checkbox"/> Mental Illness _____ <input type="checkbox"/> Drug or Alcohol Abuse _____ <input type="checkbox"/> Developmental Disability _____ <input type="checkbox"/> Psychotherapy Notes _____ <input type="checkbox"/> HIV/AIDS Testing or Treatment (regardless of result) _____ <input type="checkbox"/> Venereal Disease _____ <input type="checkbox"/> Abuse of an Adult with a Disability _____ <input type="checkbox"/> Sexual Assault _____ <input type="checkbox"/> Child Abuse or Neglect _____ <input type="checkbox"/> Genetic Testing _____ <input type="checkbox"/> Other _____	
<b>RECIPIENT: Name of person or class of persons to whom Frye Regional Medical Center may disclose my health information:</b>	
<b>ADDRESS: Address of the recipient or where my health information should be delivered:</b>	
<b>TERM: This Authorization will remain in effect:</b>	
<input type="checkbox"/> From the date of this Authorization until the ___ day of _____, 20__. <input type="checkbox"/> Until Covered Entity fulfills this request. <input type="checkbox"/> Until the following event occurs _____ <input type="checkbox"/> Other _____	
<b>PURPOSE:</b> I authorize Frye Regional Medical Center to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization: <div style="border-bottom: 1px solid black; height: 20px;"></div>	

«MedicalRecordNumber» «Room»-«Bed»  
«PatientName»  
«AttendingDoctorName»  
«Age» «Gender» «HospitalService» «FinClass»  
«PatientNumber» «BirthDate»  
«ExpAdmitDate» «AdmitDate»

\* «PatientNumber» \*

**Frye Regional Medical Center  
AUTHORIZATION TO USE AND DISCLOSE  
PROTECTED HEALTH INFORMATION**

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