

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once [ORGANIZATION] discloses my health information to the recipient, [ORGANIZATION] cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that [ORGANIZATION] may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at [ORGANIZATION]; except, however, if my treatment at [ORGANIZATION] is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case [ORGANIZATION] may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to [ORGANIZATION'S] Privacy Office at the address listed below. The revocation will be effective immediately upon [ORGANIZATION'S] receipt of my written notice, except that the revocation will not have any effect on any action taken by [ORGANIZATION] in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact [ORGANIZATION'S] Privacy Office by mail at:

_____ or by e-mail at HHH-Privacy@TenetHealth.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize [ORGANIZATION] to use or disclose my health information in the manner described above.

Signature of Patient

Date

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized
Personal Representative

Relationship
to Patient

Date

[ORGANIZATION]
ADDRESS
TELEPHONE/FAX