



**LITTLE COMPANY OF MARY  
AUTHORIZATION TO OBTAIN OR FURNISH  
PATIENT INFORMATION**

Patient Name _____		Date of Birth _____	
Address _____		City _____	State _____ ZIP _____
Phone _____	Pick Up <input type="checkbox"/>	Mail <input type="checkbox"/>	Medical Record Number _____
Treated From _____ (date)		To _____ (date)	

**I hereby authorize the protected health information regarding the above-named person be forwarded:**

**FROM: (Sender)** Name of Person/Institution \_\_\_\_\_  
 Attention \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**TO: (Recipient)** Name of Person/Institution \_\_\_\_\_  
 Attention \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Information Requested** (We cannot release information unless each applicable box corresponding to that information is checked.)

- |                                              |                                                 |                                                |                                                         |
|----------------------------------------------|-------------------------------------------------|------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Consultations       | <input type="checkbox"/> Emergency Dept. Report | <input type="checkbox"/> Lab/Pathology Reports | <input type="checkbox"/> Progress Notes/Physician/Nurse |
| <input type="checkbox"/> Discharge Summary   | <input type="checkbox"/> Face Sheet             | <input type="checkbox"/> Operative Report      | <input type="checkbox"/> X-ray/Radiology Reports        |
| <input type="checkbox"/> EKG/EMG/EEG Reports | <input type="checkbox"/> History & Physical     | <input type="checkbox"/> Physician Orders      | <input type="checkbox"/> Other _____                    |

**I understand the information to be released may include: (initial all that apply)**

- \_\_\_\_\_ Genetic Test Results
- \_\_\_\_\_ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse
- \_\_\_\_\_ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment
- \_\_\_\_\_ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

**Express Purpose for Disclosure:** \_\_\_\_\_

**Inspection:** I authorize inspection of the above records and necessary copying of same to accomplish the purpose for which the information is being disclosed. I understand that under applicable law, I have the right to inspect and copy the information to be furnished or released unless I am under the age of 12 or unless the health care professional responsible for my treatment determines in writing that access to the information would be detrimental to my health.

**Duration of Consent and Right of Revocation:** I understand this authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. This authorization form is valid until (fill in a date that is within one year after signing) \_\_\_\_/\_\_\_\_/\_\_\_\_ (will be one year after signing unless specified). I reserve the right to revoke the consent at any time. I understand that Little Company of Mary may not condition treatment or payment on my executing this authorization.

\_\_\_\_\_  
Signature of Patient Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian or Representative Date \_\_\_\_\_  
(Generally required if patient is under 18 years old or incompetent.) Relationship to Patient \_\_\_\_\_

\_\_\_\_\_  
Signature of Therapist (if applicable) Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness Date \_\_\_\_\_

**Redisclosure:** Notice is hereby given to the patient or legal representative signing this Authorization and the recipient names above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.