Bluewater Health

Authorization for Release of Personal Health Information/Personal Information

Date: ______________________________

I CONSENT TO ALLOW: (check ✓ one only)
☐ Bluewater Health
☐ Other health facility, practitioner, agency(specify) ______________________________

TO ACCESS/DISCLOSE THE FOLLOWING INFORMATION: (If applicable, specify dates of visits, contacts, hospitalization, treatment, or other information required)

CONCERNING Patient/Client Name: ______________________________
Date of Birth: ______________ Telephone #: ______________
Address: ______________________________
Person/Agency to receive information: ______________________________
Address: ______________________________ Telephone #: ______________

I understand that this information is to be used by the recipient for the purpose of:
____

Have you reviewed this information with your physician? ☐ Yes ☐ No
Name of individual picking up disclosed information: ______________________________
Address & telephone # if different than patient/client: ______________________________
I hereby waive any and all claims against Bluewater Health in connection with the disclosure of this personal information.

______________ Date
______________________________ Signature of Patient or Substitute Decision Maker & Relationship

______________________________ Signature of Witness

______________ Print Name of Translator (If Required)
______________________________ Signature of Translator (If required)

~~***OFFICE USE ONLY***~~ Verification of identity of individual receiving the access/disclosure:
Form of ID: ☐ Driver's License ☐ Passport ☐ Notarized Letter/Lawyer's Letter
☐ Other (specify) ______________________________
ID checked by ______________________________ Signature: ______________________________

<u>PLEASE NOTE</u>: This Authorization for Release Of Personal Health Information/Personal Information pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or alternate at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already released.