LABEL

Authorization - Release Of Medical Records Information Sexual Assault Examination Records

Patient Identification

Patient name: _____ Date of birth: _____
Address: _____ City/state/zip: _____
Social Security Number (last 4 digits): _____ Phone: _____

Provider (Who is releasing information?)

The following individual or organization is authorized to make the disclosure:
Provider name: _____
Address: _____ City/state/zip: _____
Phone: _____ Fax: _____

Disclose Information to: (Where is information to be sent?)

❑ Law Enforcement Agency
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Information to be Disclosed

❑ Standard Report
I am choosing to make a standard report to law enforcement. I give permission to the facility at which my examination was performed to release protected health information and any samples and specimens collected during the medical forensic examination to law enforcement agencies involved in investigating and prosecuting the suspect(s). This also includes the release of my name, contact information and other personal information obtained from me.

❑ Anonymous Storage of Medical Forensic Exam Samples & Specimens
I am choosing to have the samples and specimens collected during my medical forensic exam stored anonymously with the law enforcement agency or the medical facility in the jurisdiction where the assault occurred. I have read and understand the terms of the anonymous storage of medical forensic exam samples and specimens, which is outlined in the "Anonymous Storage of Medical Forensic Exam Samples and Specimens Option" form and have had an opportunity to ask questions to my satisfaction.

Service Dates

Dates of service from (date) _____ to (date) _____

Form and Format

Paper records

Purpose of Disclosure

❑ Law Enforcement Purposes ❑ Educational Purposes

Expiration Date

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
_____ .
If I fail to specify an expiration date, event, or condition, this authorization shall be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

Revocation

I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to:
- Information already released in response to this authorization
- My insurance company when the law provides my insurer with the right to contest a claim under my policy.

Authorization

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the facility.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Date: _____ Information sent: _____