Tri-State Memorial Hospital & Medical Campus

PERPETUAL AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

Patient Information

Patient Name _____ Date of Birth ____/____/_____

Previous Name, If Applicable _____ Phone Number _____

Consent Information

I. I authorize Tri-State Memorial Hospital & Medical Campus to leave messages for the above patient.

II. I authorize Tri-State Memorial Hospital to disclose my health care information to the individual(s) listed below who may inquire on my behalf about medical issues.

Name _____ Relationship to patient _____
Address _____ City_____State_____Zip _____

Name _____ Relationship to patient _____
Address _____ City_____State_____Zip _____

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Address _____ City_____State_____Zip _____

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Address _____ City_____State_____Zip _____

Name _____ Relationship to patient _____
Address _____ City_____State_____Zip _____

Name _____ Relationship to patient _____
Address _____ City_____State_____Zip _____

Tri-State Memorial Hospital may disclose the following health care information (please check all that apply)

- ❑ All health care information in my medical record (see next section to release protected health information)
- ❑ Related to the following treatment or condition _____
- ❑ For the date(s) of _____
- ❑ Other (e.g., x-rays, bills) specify date(s) _____

Tri-State Memorial Hospital may disclose health care information regarding testing, diagnosis, and treatment for (please check all that apply)

- ❑ HIV (AIDS virus)
- ❑ Sexually transmitted diseases
- ❑ Reproductive health **(ONLY THOSE UNDER 18 YEARS OF AGE)**
- ❑ Psychiatric disorders/mental health
- ❑ Drug and/or alcohol abuse

This authorization shall continue in perpetuity from the date signed or until my 18 birthday unless revoked as below.

III. I understand I may revoke this authorization in writing to the address of the office named above. If I do revoke this authorization, it will not affect any actions already taken by Tri-State Memorial Hospital based upon this authorization.

_____ _____
Print Name of Patient or Legally Authorized Individual — Patient or Legally Authorized Individual Signature

Date _____/_____/_____ Time _____ Relationship _____