

Authorization to Release Health Information

I give permission to _____
Medical Facility City/State Zip

to release information from the medical record or release protected health information for:

Patient Name Social Security # Date of Birth

*Review of records of patients possibly
exposed to hydraulic fluid residue*

Purpose of Release of Information Date of Encounter/Visit Daytime Phone #

Send information to:

**Long-Term Monitoring Program/Project240
c/o PharmaLinkFHI
P.O. Box 528
Morrisville, NC 27560**

Fax: 919-313-1463

Registration Center Phone: 866-614-1183

Circle one of the following choices to indicate the information to be released:

1. A complete copy of my medical record from _____ (date) to _____ (date)
2. Specific protected health information necessary for review following possible exposure to hydraulic fluid residue

Check those that apply:

- | | |
|--|----------------------------|
| _____ pathology report | |
| _____ discharge summary | _____ order sheet |
| _____ x-ray reports | _____ physical examination |
| _____ history and physical examination | _____ clinical record |
| _____ operative report/procedure note | _____ progress notes |
| _____ lab results | |
| _____ other, specify: _____ | |

I understand that I may withdraw this authorization by written notice to the Medical Facility described above. I may do so at any time except to the extent that the information has already been released prior to this authorization and/or before I have withdrawn my authorization. Otherwise, this authorization shall continue to be valid only for as long as reasonably necessary to carry out the purpose detailed above. A covered entity may not stipulate treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this authorization. I understand that in the event the organization chooses to use or release my information to another entity that is not a healthcare provider, health plan or business associate of such organization, the released information may no longer be protected by federal privacy regulations. I understand that I am entitled to a copy of this authorization.

Patient/Representative Signature

Date Signed

Representative's Relationship to Patient

Witness

If you signed as a representative of the patient, read the following and sign below:

I, _____, hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have the lawful authority to enter into this authorization on behalf of such individual. I have read the provisions set forth in this authorization, and agree that the medical facility named above may share the medical record information of such patient for the purpose described in this document.

Signature

Date Signed