My Record

AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION – RELAY HEALTH

PATIENT LABEL

or

M#: ______________________________

V#: ______________________________

(For Department Use Only)

COMPLETE ALL INFORMATION ON FORM

Patient's Full Legal Name: ______________________________

E-mail Address: ______________________________

Date of Birth: ______________ SS #: ______________ Telephone Number: ______________

Address: ______________________________

I hereby authorize the following individuals or organizations to have access to my medical record through **My HMH Record (powered by RelayHealth)**:

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I hereby authorize Hardin Memorial Health to use or disclose the portion of my health record available through **My HMH Record (powered by RelayHealth)**. This would include lab results, radiology reports and physician dictated reports. I understand that the information on **My HMH Record (powered by RelayHealth)** is not a complete compilation of my Hardin Memorial Health visits and only contains pertinent information. My Health record may include information related to pregnancy, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse.

Federal law protects the information disclosed pursuant to this authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected.

This authorization will expire upon the occurrence of the following date or condition: upon written revocation for adults 18 years of age and older and/or upon the date of the 18th birthday for any minors covered by this authorization. I understand that in order to revoke this authorization I must present a written revocation to Health Information Management Services at Hardin Memorial Hospital.

______________________________ ______________

Signature of Patient/Authorized Representative **Date/Time**
(Include relationship or nature of authority)

______________________________ ______________

Signature of Hardin Memorial Hospital Staff verifying identification **Date/Time**

______________________________ ______________

Signature of Witness if not signed in presence of Hardin Memorial Hospital Staff **Date/Time**