Healogics
The power to heal

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information	
PATIENT NAME	
ADDRESS	
CITY/STATE/ZIP	PHONE NUMBER
DATE OF BIRTH / /	HOSPITAL NAME

I authorize Healogics to use or disclose protected health information as described below

Information About Who Is Authorized to Receive Patient's Information
NAME
ADDRESS 1
ADDRESS 2
CITY, STATE, ZIP
PHONE NO.
EMAIL ADDRESS (if electronic disclosure)

Purpose of the Use/Disclosure (Check at least one)
☐ INSURANCE
☐ ATTORNEY
☐ AT THE REQUEST OF THE INDIVIDUAL
☐ OTHER (SPECIFY)
☐

Description of Information Authorized to Be Used/Disclosed (Check all that apply)

☐	Complete Record	☐	Laboratory Reports	☐	Progress Notes
☐	Record Summary	☐	Imaging Reports (like x-rays, CTs, MRIs)	☐	Nursing Information
☐	Discharge Summary	☐	Pathology Reports	☐	Billing Records
☐	Physician Orders	☐	Other _____	☐	Medication Records

Date Range of Information to Be Used/Disclosed	
	☐ All Dates of Service
	☐ Specific Date Range Start Date / / End date / /

By signing this authorization, I agree to the following:

- I understand if I authorize protected health information to be released to a party not subject to federal privacy laws, it is possible the information may be re-disclosed by the recipient and the information may no longer be protected under privacy laws.
- I understand that authorizing the use and/or disclosure of this health information is voluntary and that I am not required to sign this authorization. I understand I do not need to sign this form in order to receive treatment.

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- I understand that I can revoke this authorization in writing at any time by contacting the wound care center where I (the patient) received care, but revoking this authorization does not affect any circumstance where Healogics has acted in reliance of this authorization.
- I understand that if I request an electronic copy of my medical records and the information is given to me on unencrypted media (such as a flash drive or CD), I should protect the media, because the information is not protected from being accessed if it is lost or stolen.
- This authorization expires six months from the date on which it was signed, unless otherwise specified. (Otherwise specified date, event, or condition: _____)

_____	_____
Signature of Patient or Personal Representative	Date
_____	
If not signed by patient, list personal representative's authority to act for the patient	

A copy of this authorization must be provided to the patient/personal representative.