Jackson County Memorial Hospital
Authorization for Access by Patient or Disclosure of
Protected Health Information

Patient Name: ____ Medical Record#: _______________

Date of Birth: ____ Social Security#: ________________

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of Individual/Facility/Company to Receive PHI

Women's Imaging
Jackson County Memorial Hospital
1200 E Pecan, PO Box 8190
Altus OK 73522
Phone 580-379-6050
Fax 580-379-5449

Name of Individual/Facility/Company to Disclose PHI

☐ Jackson County Memorial Hospital

☐ ____________________________________
Facility
____
Address
____
City, State, Zip Code
____
Telephone
____
Fax

Type of Records Requested
♦ Health care information related to the following treatment or condition________________________

*MAMMO FILMS & REPORTS
Please send CD if available__________

☐ Laboratory/Diagnostic Tests__________________

☐ Other__________________________________

This is a

____PERMANENT TRANSFER

____TEMPORARY TRANSFER

The information will be obtained, used or disclosed for the following purpose(s) only: ☐ Insurance ☐ Continued Treatment ☐ Legal
☐ At the request of the patient's representative ☐ Other:____

ACR CITATION 900.12 (c) (4)(ii): Each facility that performs mammograms:(ii) shall upon request by, or on behalf of, the patient, permanently or temporarily transfer the **original mammograms and copies of the patient's reports to a medical institution, or to a physician or health care provider of the patient, or to the patient directly.*

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I understand that I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:

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I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected *health information* covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I have the right to inspect the health information to be released and I may refuse to sign this authorization. Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as Acquired Immune Disease Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

______________________________________ ______________________________
Signature of Patient or Legal Representative Date

______________________________________ ______________________________
Description of Legal Representative's Authority Expiration Date of Authorization

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.
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