MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
ADMISSIONS	NAVHOSPPNCLAINST 6010.9X	20 Jan 2016

LOCAL FORM TITLE *(Optional)*
INPATIENT DIRECTORY AUTHORIZATION

Authorization for the Use and Disclosure of Individually Identifiable Health Information

Instruction:

1. Place the original with the patient's inpatient record
2. Deliver a copy to the information desk (1st floor main hospital)
3. Deliver a copy to the applicable ward upon admission
4. Deliver a copy to the patient

1. Do you wish the following information be released in Naval Hospital's inpatient directory? You are not required to consent to the release of this information.
   1. Name
   2. Location
   3. Condition, in the following general terms: **GOOD, FAIR, CRITICAL, UNKNOWN, DECEASED**
   4. Religious affiliation - information is released only to clergy associated with your religious affiliation

☐ Yes _____ ☐ No _____

2. If the opportunity to object cannot practically be provided because of the individual's incapacity or an emergency treatment circumstance, a covered health care provider may use or disclose some or all of the above information for the facility's directory, if such disclosure is:

   1. Consistent with prior expressed preference of the individual, if any, that is known to the covered healthcare provider; and
   2. In the individual's best interest as determined by the covered healthcare provider, in the exercise of professional judgment.
   3. The covered healthcare provider informs the individual and provides an opportunity to object to uses or disclosures in our directory when it becomes practicable to do so.

3. The person or organization authorized to use or disclose the information will not receive compensation for doing so.

4. I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 6 and 7 on this form.

5. If the purpose of this authorization is for Naval Hospital Pensacola to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, Naval Hospital Pensacola reserves the right to deny enrollment or eligibility for benefits.

6. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Naval Hospital Pensacola reserves the right to deny that health care.

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this authorization at any time by notifying Naval Hospital Pensacola in writing, except to the extent that:
   a) action has been taken in reliance on this authorization; or
   b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

9. I understand that I have a right to request and receive a Notice of Privacy Practices from Naval Hospital Pensacola.

10. This authorization expires on [upon] _____

examples: on [date], upon discharge from hospital on or about [date], until I update this form.

_____ Signature of patient or patient's representative

_____ Date

_____ Printed name of patient or patient's representative

_____ Relationship to patient, or patient's representative's authority to act for the patient, if applicable

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	