



**Authorization for Release of Electronic Health Information to  
Personal Health Record (PHR) – My Care Corner- ADULT**

I hereby authorize Webster Memorial Hospital to release any and all of my health information (**including information related to AIDS or HIV; sexually transmitted diseases; psychiatric/behavioral health information; alcohol and/or drug testing or treatment; or pregnancy related testing and treatment**) beginning with information from March 2015 and continuing with all future information, unless I revoke this authorization in writing (see revocation statement below).

**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

This information is to be released electronically via My Care Corner to: \_\_\_\_\_ self, or

|      |               |                         |
|------|---------------|-------------------------|
| Name | Date of Birth | Relationship to Patient |
|------|---------------|-------------------------|

|      |               |                         |
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| Name | Date of Birth | Relationship to Patient |
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|      |               |                         |
|------|---------------|-------------------------|
| Name | Date of Birth | Relationship to Patient |
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for the purpose of viewing electronic medical information on-line.

**Revocation:** I understand this authorization will remain in effect until I revoke it. I may revoke it in writing at any time, except to the extent that action has been taken in reliance on this authorization. Revocation can be performed by submitting a request **in writing** to the Medical Records Department at Webster Memorial Hospital, with a statement that the patient wishes to revoke their prior authorization. **All written revocations should be dated and signed by the patient.**

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Webster Memorial Hospital will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

**Signed:(patient)** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_ **Date** \_\_\_\_\_  
**(or Legal Representative)** **(Relationship to Patient)**

