

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

For internal use only:

MRN: _____

Patient Name _____
(Please Print) Last First M/I
Date of Birth _____ Social Security Number (last four digits) _____
Address (Street) _____ Phone Number (____) _____

(City, State, Zip Code) _____
E-mail _____

Location(s)/Facility _____

Treatment Date(s) _____

Please Release Medical Information to the Following Recipient: ☐ Release to self; same info as above

Name of Person or Organization _____ Phone # _____

Address _____ Fax # _____

Purpose of Disclosure ☐ Continuity of care ☐ Legal / Attorney ☐ Disability ☐ Personal use ☐ Other _____

Description of Information to be Released:

- | | | |
|---|---|--|
| ☐ Pertinent Summary (includes all * items) | ☐ Facesheet / Demographics | ☐ Physical Therapy |
| ☐ Admission Form | ☐ Lab Reports | ☐ Entire Record |
| ☐ *Discharge Summary | ☐ *Radiology Report | ☐ Physician's Notes |
| ☐ *Emergency Room Report | ☐ *EKG Report | ☐ Radiology images (electronic) |
| ☐ *History & Physical | ☐ *Pathology Report | ☐ Other _____ |
| ☐ *Consultation Report | ☐ *Card Cath Report | |
| ☐ *Operative Report | | |

I, the undersigned, authorize _____ (Disclosing Institution) and its employees to release Information from my medical records as described above. I understand and acknowledge that the medical record may contain Information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that Information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my Information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of Information and accept financial responsibility.

X _____ / _____ / _____
Signature of Patient/Legal Representative** Date Signed

Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

☐ Patient unable to sign

- ☐ By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from obtaining a copy of the requested records.