

AUTHORIZATION TO RELEASE MEDICAL RECORDS



I, _____, who resides at _____

In the city of _____ in the state of _____ hereby authorize:

Name:
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)
Address:
City, ST, Zip:

To disclose the following specific medical information by mail or fax or hand delivery:

Name:
Address:
City, ST, Zip:

From the Health Records of:

Name:
(NAME OF INDIVIDUAL WHOSE HEALTH RECORD IS BEING DISCLOSED)
Address:
City, ST, Zip:

For the purpose of: _____

My authorization extends only to those data elements/ documents initialed below:

- _____ Statements of charges or payments.
- _____ Records of visits (all visits.)
- _____ Record of visit for a specific date or dates. Specific dates include or are limited to: _____
- _____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc.)
- _____ Progress Notes
- _____ Photographs, videotapes, digital or other images
- _____ Discharge Summary
- _____ History and Physical Examination
- _____ Consultation Reports
- _____ All of the above
- _____ Other (Must be specific) _____
- _____ Mental health and/or alcohol and drug abuse treatment
- _____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information
- _____ Hepatitis Information



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This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a six month (6) period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the H.I.M. Department.
4. D.M. Cogdell Memorial Hospital, 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.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

PATIENT'S NAME PRINTED

Date

PATIENT'S SIGNATURE (Guardian, if minor)

Expiration Date
(If other than six months from date above.)

SOCIAL SECURITY NUMBER (for identification purposes only)

PATIENT'S PERSONAL REPRESENTATIVE

Date

(Patient's Personal Representative's Authority To Act)

SOCIAL SECURITY NUMBER (for identification purposes only)