PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME:_____ DOB:_____

MR#: _____ Account Number: _____ Phone#:_____

I authorized Medical/Clinical Information for the above patient, (please check only one box).

☐ To be sent **FROM** Memorial Hospital to the **FOLLOWING:**

Or

☐To be sent **TO** Memorial Hospital from the **FOLLOWING:**

_____

_____

_____

FOR THE PURPOSE OF:_____

DATES OF CARE INCLUDE:_____to_____

DATE REQUESTED:_____ **REQUEST REC'D BY:** _____ ☐ **MAIL OUT** ☐ **PICK UP** ☐ **FAXED INFORMATION**

REQUESTED:

_____ History and Physical	_____ Operative Report	_____ Laboratory
_____ Discharge Summary	_____ EKG's	_____ Consultation
_____ Imaging Report	_____ Other	_____ Emergency Notes

_____ Imaging CD [exams]:_____

- I understand that this authorization may be revoked in writing and delivered to the HIS Department of Memorial Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining authorization AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

EXPIRATION DATE: This authorization will expire on [date or event] _____. (If no date or event is stated, expiration is 60 days from the date it was signed).

_____ _____

Signature of individual or representative Date

_____ _____

[Authority or relationship of representative] Date

Request Processed by: **HIS** or **RAD** initials:_____ Date:_____ DATE MAILED OUT: _____ DATE PICKED UP:_____

****SPECIAL AUTHORIZATION:** Drug/Alcohol Abuse, Mental Health Information and/or AIDS information.

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to one or more above. My signature below authorizes release of all such information.

_____ _____

Signature of individual or representative Date

_____ _____

[Authority or relationship of representative] Date