Doctors' Memorial Hospital

Authorization to Release Medical Information
(If under 18 years of age, parent or guardian must sign)

Name of Patient:	Patient MR#:	Date of Service:
Patient Address:	Date of Birth:	Phone:

I authorize and request the release of medical records FROM Doctors' Memorial Hospital and wish to disclose same TO:

Name_____ **Address**_____

City/State_____ **Zip**_____

For the purpose of:

☐ Continuation of medical treatment	☐ Payment of bill	☐ Worker's compensation
☐ Personal use	☐ Legal or insurance purposes	☐

The information to be disclosed is:

	Account #'s		Account #'s
☐ Discharge Summary	_____	☐ Operative reports	_____
☐ History & physical	_____	☐ X-ray reports	_____
☐ Laboratory reports	_____	☐ Pathology reports	_____
☐ Consultations	_____	☐ Other (specify)	_____

_____(initial) I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or Hepatitis. It may also include information about behavior or mental health services, and treatment for alcohol and drug use.

_____(initial) I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about, or medical records of my medical condition to those persons or agencies names above. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C. F. R. Part 164). A photocopy of this authorization shall have the same effect as the original.

_____(initial) The staff at Doctors' Memorial Hospital may leave discrete telephone messages on my personal answering machine or at another number that I provide.

If the patient is a minor, this authorization must be signed by a parent or legal guardian. If the patient is physically unable to sign this authorization, he/she should put an "X" on the signature line and have his/her assent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may only be signed by the next-of-kin or personal representative of the estate.

Unless revoked in writing this authorization will NOT expire.

I understand that this consent is revocable by me, in writing, at any time except to the extent this action has been taken in reliance to it.

_____ _____

Signature of Patient **Date**

_____ _____ _____

Consenting party signing in lieu of patient **Relationship** **Date**

_____ _____

Witness of Signature **Date**