

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME: _____ D.O.B.: _____

ADDRESS: _____ PHONE #: _____

CITY: _____ STATE: _____ ZIP: _____ ACCT #: _____

I hereby authorize Community Memorial Hospital and all programs, departments, and clinics to use and/or disclose my health information as follows:

DISCLOSE TO: _____
RECIPIENT NAME ADDRESS

PHONE NUMBER RELATIONSHIP TO PATIENT CITY STATE ZIP CODE

PURPOSE OF DISCLOSURE: _____

- Check this box if disclosure is at the request of the individual.
- If the purpose for the disclosure is marketing, check this box only if CMH will receive direct or indirect remuneration from a third party.

INFORMATION TO BE DISCLOSED:

<input type="checkbox"/> Complete record	<input type="checkbox"/> Discharge Report
<input type="checkbox"/> History and physical examination	<input type="checkbox"/> After care plan
<input type="checkbox"/> Progress notes	<input type="checkbox"/> Lab reports
<input type="checkbox"/> Consultation reports	<input type="checkbox"/> X-ray reports
<input type="checkbox"/> Emergency room record	<input type="checkbox"/> Billing record

I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATING TO:

<input type="checkbox"/> Substance Abuse (including alcohol/drug abuse)
<input type="checkbox"/> Mental Health
<input type="checkbox"/> HIV/AIDS related information (including test results)

DATE OF SERVICE OR TIME PERIOD OF RECORDS TO BE DISCLOSED: _____
(STATE TIME PERIOD OR "ALL")

I UNDERSTAND AND ACKNOWLEDGE THAT:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at the organization.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.
3. This authorization is effective for _____ months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to the organization. My revocation will not be effective to the extent action that have already been taken in reliance on my authorization.
4. I have read (or had read to me) and received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

SIGNATURE OF THE PATIENT OR PATIENT'S PERSONAL REPRESENTATIVE

DATE

RELATIONSHIP TO PATIENT IF SIGNED BY PERSONAL REPRESENTATIVE