CONSENT FOR RELEASE OF MEDICAL RECORDS

The Undersigned authorizes____
(NAME OF HEALTHCARE FACILITY)
to release copies of certain medical record information as specified below:

PATIENT NAME:______________________________BIRTH DAY:____________

SOCIAL SECURITY NUMBER:__________________PHONE NUMBER____________

ADDRESS:______________________CITY:__________STATE:____ZIP:________

DATES OF TREATMENT:____

INFORMATION NEEDED:
- ☐ HISTORY AND PHYSICAL
- ☐ OPERATIVE REPORTS
- ☐ XRAY REPORTS
- ☐ XRAY FILM
- ☐ PATHOLOGY REPORTS
- ☐ DISCHARGE SUMMARY
- ☐ LABORATORY REPORTS
- ☐ PROGRESS NOTES
- ☐ OTHER__________

INFORMATION TO BE RELEASED TO:

NAME:____

ADDRESS:____

CITY:____________________STATE:_____ZIP:__________

FAX:_____________________PHONE:__________________

PURPOSE OF NEED FOR THIS DISCLOSURE:____

I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME PRIOR TO ACTION BEING TAKEN. DUE TO THIS AUTHORIZATION FOR RELASE, I UNDERSTAND THAT THE INFORMATION AUTHORIZED FOR RELEASE MAY INDICATE THE PRESENCE OF A COMMINICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOR LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN INNUMODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

NOTICE TO RECIPENT OF COPIES AS ALCOHOLAND DRUG ABUSE MEDICAL RECORDS:

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Chap 1, Part 2 Subpart C 2.32). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Chap. 1, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 for the first offense and $5000 in the case of a subsequent offense.

THIS DOCUMENT SPECIFICALLY AUTHORIZES THE RELEASE OF PHYCHIATRIC INFORMATION, IF PSYCHIATRIC INFORMATION IS INCLUDED IN THE INFORMATION TO BE RELEASED TO THE PATIENT, THE PHYSICIAN AUTHORIZATION ON THE BACK OF THIS FORM MUST BE OBTAINED. THE UNDERSIGNED HAS REVIEWED THE LANGUAGE ON THE BACK LISTING THE REPORTABLE COMMUNICALBE OR VENEREAL DISEASES AND CONFIDENTIALITY AND DISCLOSURE REQUIREMENTS REGARDING SUCH DISEASES.

With this knowledge, I give my consent to the release of all information in my medical records, including information concerning my identity and release. The Heart and Medical Center and/or its employees from any liability in connection with the release of the information contained therein.

________________ ____________________________________
Date Patient Signature

COMPLETE THE FOLLOWING IF PATIENT IS DECEASED, A MINOR OR MENTALLY INCAPACITATED. CONSENT MAY BE GIVEN BY A LEGALLY AUTHORIZED REPRESENTATIVE, IDENTIFIED BELOW:

REASON UNABLE TO SIGN:____

________________ ____________________________________ ____________________
Date Signature Relation

Note: This Content will be honored for a period of 180 days following it execution.

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