

AUTHORIZATION FOR RELEASE OF INFORMATION
(Photocopies of this consent in its original form shall be acceptable)

Date of Request: _____

Patient Name: _____ Date of Birth: _____ SS#: _____

I hereby authorize **Childress Regional Medical Center** to release information related to the treatment of the above reference patient.

Information to be released: (please check all information requested)

- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X/ray Imaging Reports | <input type="checkbox"/> Respiratory Therapy Notes |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> EKG Reports | <input type="checkbox"/> Nurses Notes |
| <input type="checkbox"/> Progress Note | <input type="checkbox"/> Physical Therapy Notes | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Consultations | <input type="checkbox"/> Other (Specify) _____ |

Treatment Dates Covering: From: _____ To: _____

Release To: _____ Address: _____

For the purpose of: _____

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

Yes, I consent to the release of this information **No**, I do not consent to the release of this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides any insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact CRMC Compliance Officer.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

*******COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT*******

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness