FOR INTERNAL USE ONLY:

MR# _____
Pick Up Date: _____
□ Records have been mailed/Picked up
□ Records have been faxed.
FAX#: _____
□ Records have not been sent.
Reason: _____
Initials: _____ Date: _____

CMH Community Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION INFORMATION:

PATIENT NAME:		DATE OF BIRTH:	
ADDRESS:	CITY	STATE	ZIP
PHONE NUMBER: Home:_____ Work: _____ Other: _____			

This will authorize: (Check One) □ Community Memorial Hospital & SHCC □ Other (Name and address below)

NAME/ORGANIZATION: _____

STREET ADDRESS: _____

CITY: _____STATE: _____ ZIP CODE: _____

To Release Records to (Check one) □ Community Memorial Hospital & SHCC □ Other (Name and address below)

NAME/ORGANIZATION: _____

STREET ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____

RECORDS TO BE RELEASED: (Please indicate below which items you want released)
Note: dictated reports are not official until they are authenticated/signed by the author/physician

□ Lab Reports
□ History & Physical
□ Discharge Summary
□ Operative Reports
□ Pathology Reports
□ Emergency Service Reports
□ Imaging (X-ray) Reports
□ Imaging (X-ray) Film
□ Consultation Notes
□ Physical Therapy
□ Occupational Therapy
□ Speech Therapy
□ Physician Office Notes
□ Billing and/or statements
□ Other (specify): _____

For the following date(s) of treatment or condition:_____
(SPECIFY DATES OF TREATMENT OR CONDITION)

PURPOSE OF RELEASE:

□ Continued Care
□ Personal Use
□ Insurance
□ Work Comp
□ Litigation/Legal
□ Other (specify): _____

TO THE PATIENT:

I understand I may revoke this authorization by written request to the Health Information Dept of releasing facility. I understand that the revocation will not apply to information that has already been released in response to this authorization.
Upon fulfillment of the above stated purposes, this authorization will automatically expire one year from the date of my signature.
I understand that all records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing will be released unless indicated by initialing here: _____. Please specify any restrictions: _____
I understand that once information is released pursuant to this authorization, re-disclosure of the information by the recipient cannot be prevented.
A fax or photocopy that has not been altered will be considered as valid as an original.
I understand there may be a retrieval and copy charge associated with the release.
I understand authorizing the release of this information is voluntary. I need not sign this authorization to receive healthcare treatment.

_____ _____
SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE DATE

If signing as the authorized representative of the patient, I am: (please check one)

□ the court appointed guardian or conservator of the patient (Legal Documentation Required)
□ a custodial parent of a minor
□ other (specify): _____

TO BE COMPLETED BY CMH STAFF:

Identification of Requestor Verified? □ Method: _____ Verified by: _____