Clark Memorial Hospital

A Norton and LifePoint Partnership

❑ Account # _____

❑ MR # _____

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____

(Name of Patient) (Date of Birth) Daytime Phone

_____

(Address) (City) (State) (Zip)

Dates of Treatment or Service: _____

I authorize Dr. _____ ,Clark Physician Group, to **DISCLOSE** information specified below to:

Name: _____

Address: _____

City/State: _____

Phone: _____

Fax: _____

I authorize Dr. _____,Clark Physician Group, to **OBTAIN** information from:

Name:_____

Address: _____

City/State: _____

Phone: _____

Fax: _____

Information to be Disclosed

_____Diagnosis/Dates of Treatment
_____Discharge Summary (includes diagnosis, history, results of treatment, prognosis)
_____History and Physical
_____Emergency Room Records
_____Entire Record
_____Consultation
_____Other, explain: _____

_____Operative Report
_____HIV (AIDS or AIDS related information)
_____Lab Results (Specified Date or All) _____
_____(X-rays, EEG, EKG, etc.)
_____ Psychological/Psychiatric Evaluation
_____Pathology
_____ Letter confirming attendance/treatment

Purpose or Need For the Disclosure: ❑ Physician / Hospital - Continuity of Care ❑ Personal Use ❑ Legal ❑ Disability

❑ Other, Explain: _____

❑ Electronic copy of my health information. I understand that I will be given a flash/USB/thumb drive and it is my responsibility to secure the information and it is no longer the property of Clark Memorial Hospital or Clark Physician Group.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail an expiration date, event or condition, this authorization will expire in 60 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I understand 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.

I understand that if I have been treated for drug or Alcohol abuse my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Date: _____ _____

*Signature of Patient or Legal Guardian

Witness:_____ _____

Relationship to Patient

❑ CPG has permission to fax my Health Information to: _____

Fax #

ID Verification No.: _____ Copied By:_____

Date Released: _____

S/M
CONSENTS

MR190