Clark Memorial Hospital
A Norton and LifePoint Partnership

Clark Physician Group
A Norton and LifePoint Partnership

AUTHORIZATION FOR RELEASE OF INFORMATION

❑ CPG MRN # _____
❑ Account # _____
❑ MR # _____

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

Dates of Treatment or Service: _____

I authorize Clark Memorial Hospital and/or Dr._____, Clark Physician Group to **DISCLOSE** information specified below to:

Name: _____
Address: _____
City/State: _____
Zip Code: _____Phone: _____

I authorize Clark Memorial Hospital to **OBTAIN** information from:

Name:_____
Address:_____
City/State: _____
Zip Code: _____Phone:_____

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
_____ Radiology Images
_____ Physician Office Notes

_____ 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
_____ Drug or Alcohol Abuse Records
_____ Other: _____

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 CD 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, and treatment cannot be conditioned upon obtaining the authorization.

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

ID Verification No.: _____ Copied By:_____

Date Released: _____

S/M
ROI

MR502