

**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

- | | |
|--|--|
| <input type="checkbox"/> Diagnosis/Dates of Treatment | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Discharge Summary (includes diagnosis,
history, results of treatment, prognosis) | <input type="checkbox"/> HIV (AIDS or AIDS related information) |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Results (Specified Date or All) _____
(X-rays, EEG, EKG, etc.) |
| <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> Psychological/Psychiatric Evaluation |
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Letter confirming attendance/treatment |
| <input type="checkbox"/> Radiology Images | <input type="checkbox"/> Drug or Alcohol Abuse Records |
| <input type="checkbox"/> Physician Office Notes | <input type="checkbox"/> 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: _____

