MR#_____ ACCT#_____

Authorization to Release Health Information

I, _____, hereby authorize **Clinton Memorial Hospital** (the "Facility") to disclose health information regarding the following patient:

Patient Name		Patient Account Number	
Patient Address		Date of Birth	
City, State, Zip		Social Security Number	XXXXXXXXXXXXXXXXXXXXXXXXX
Patient Phone Number		Date of Death	

The information is to be disclosed to the following persons or organizations:

Recipient Name			
Address		City, State, Zip	
Recipient Phone Number			

The purpose of the use of this disclosure is: ☐ At the request of the patient: or ☐ Other (specify):

If the purpose is for marketing, will the facility receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

Information to be disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around the following dates (*insert dates*):

☐	Entire medical record	☐	HIV/AIDS test results and treatment	☐	Progress notes
☐	Lab results	☐	Mental or behavioral health records	☐	Photographs, videotapes, or other images
☐	Treatment plan	☐	Alcohol and drug treatment records	☐	Summary of treatment
☐	X-ray reports	☐	Genetic test results	☐	Consultation reports
☐	Admission notes	☐	Psychotherapy notes	☐	History and physical exam
☐	Discharge summary	☐	The following billing and payment information:		
☐	Other (specify):				

1. **Revocation.** I understand that I may revoke this authorization at any time by sending a written notice to the Facility. However, the revocation will not have any effect on any uses or disclosures the Facility may have made before the revocation was received.
2. **Expiration.** I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.
3. **Re-disclosure.** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party.
4. **Refusal to Sign.** I understand that I may refuse to sign this Authorization and that the Facility will not condition treatment on whether I sign this Authorization.
5. **Certification.** I certify that I am (check whichever applies):
   - ☐ The patient and the identification that I have provided is true and correct.
   - ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of:

Signed this day _____ of _____, 20____.

Signature of person completing form: _____ **Date:** ____/____/_____

Printed Name: _____

Address (if different from above): _____

Phone (if different from above): _____

Witness: _____ **Date:** ____/____/_____

Printed Name: _____

For Facility Use Only:		
Date Received:		
How was identity verified?		Copy made? ☐ Yes ☐ No
How was authority verified?		Copy made? ☐ Yes ☐ No
Name of person accepting form:		
Title		