Medical Records Department

HOSPITAL

Phone: (301) Fax: (301)

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Telephone No: _____

Dates of Treatment: _____

Medical Record # : _____ Social Security # : _____

☐ Inpatient ☐ Outpatient ☐ Emergency

I AUTHORIZE THE MEDICAL RECORDS DEPARTMENT TO RELEASE THE FOLLOWING INFORMATION:

☐ Summary or Abstract	☐ Operative Report	☐ Nurses Notes
☐ Entire Medical Record	☐ Anesthesia Record	☐ Emergency Room Notes
☐ Discharge Notes	☐ Pathology Report	☐ Medication Record
☐ Admission History & Physical	☐ Diagnostic/X-Ray Reports	☐ Progress Notes
☐ Consults	☐ Laboratory Results	☐ Other: _____
☐ Physician's Orders	☐ Psychotherapy Notes or mental health records	

Please send information to:

_____

_____

_____

_____

Purpose:

☐ At my request ☐ Other: _____

If your medical record contains any records obtained from other providers (Please check one):

☐ I prohibit their release:

☐ I authorize and request their release [unless prohibited by the other provider(s)].

This Authorization is valid for up to ***12 months from the date of signature***, unless a shorter period is listed below.
Expiration Date or Event: _____

I understand that I may refuse to sign this Authorization. If I do not complete this Authorization, it will not affect the use or disclosure of my protected health information for purposes of treatment, payment or eligible for benefits. I can change my mind at any time and revoke in writing my permission to allow my protected health information to be used or disclosed under this Authorization, except to the extent Holy Cross Hospital relied on this Authorization.

I understand that Holy Cross Hospital will not release my protected health information to others except as authorized by me or permitted by law. Once my protected health information is shared with a group or individual that is not required to follow federal privacy laws, Holy Cross Hospital cannot assure that the information will remain confidential.

_____ _____ _____

Signature of Patient or Representative Date Relationship to the Patient

NOTE: There is an $19.09 base fee and 0.63¢ per page fee for the processing of copies of medical records for third party requestors. For patient access there is a fee of 0.63¢ per page copied. There is no fee for sending copies of medical records to physicians or other health care providers.

9/15/2003