County Hospital
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________ Patient's Name

______________________________ Patient's Address

______________________________ Patient's Date of Birth

______________________________ Patient's Telephone Number

The Undersigned hereby authorizes County Hospital in Kentucky, to release the following portions of the Medical Records of the above named patient:

Please Circle:

- Facesheet (Demographics)
- Discharge Summary
- History & Physical
- Consult
- Progress Notes
- Lab
- Radiology Report ______________
- Radiology Films only ______________
- Cardiopulmonary
- E.R. Record
- Other: ______________

For the following period of ______________ to ______________

__________ Entire Medical Record for period of ______________ to ______________

* *

Agency Requested From:

Facility ______________ DOB ______________

Adm. Date ______________ Exp. Date ______________

SSN ______________

* *

Release this information to:

Name of Person or Institution: ______________

Address of Person or Institution: ______________

The Medical Record is needed for the following purpose: ______________

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I understand that I may REVOKE this release at any time, in writing, but the request shall remain valid for 90 days, unless revoked, whichever occurs first. I also understand that this release may include medical records of treatment for PHYSICAL and/or EMOTIONAL illness, including treatment of ALCOHOL or DRUG Abuse. I also understand the HIV, or AIDS-RELATED INFORMATION may also be released.

______________________________ Signature

______________________________ Date of Signature

______________________________ Relationship (If other than Patient)

______________________________ Witness