5-Hole 1/4 1 3/8 c-to-c

Release of Information
☐ Authorization or ☐ Requisition Form

Section A: *This section to be completed by the patient.*				
Patient Name:			**Medical Record #:**	
Address:			**Social Security #:**	
			Date of Birth:	
Name of Disclosing Hospital/Provider	**Facility Name:**			
	Address:			
	City/State/Zip:			
	Phone #:			
Name of Recipient	**Requestor Name:**			
	Address:			
	City/State/Zip:			
	Phone:			
Date(s) of Service:				

Do you want the hospital to release your psychotherapy notes (if any to the person or facility you have listed above? (Circle one) YES NO

List specific description of information to be released:	☐ Anesthesia ☐ Billing Records ☐ UB92 ☐ Itemized Bills ☐ Consultation	☐ Discharge Summary ☐ EKG's ☐ Emergency Records ☐ Face Sheet ☐ History & Physical	☐ X-Ray Reports/Films ☐ Laboratory ☐ Medication Records ☐ Nursing Records ☐ Operative Report	☐ Physician Orders ☐ Outpatient Records ☐ Pathology Report ☐ Progress Notes ☐ Acct of Disclosure	☐ All Records ☐ Abstract ☐ Other: _____ _____ _____

Section B: *Must be completed by the Patient or Patient's Representative for all authorizations:*

The Patient or the Patient's Representative must read/acknowledge the following statements:

1. I understand that the persons hereby authorized to use/disclose **information** will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on ____/____/_____. ***(If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)***
3. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
4. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
5. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
6. I understand there may be information released regarding my treatment of AIDS/HIV, Psychiatric Care, and/or Treatment for alcohol and/or drug abuse. I authorize for this release _____ (initial here)
7. I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
8. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.

Patient/Patient's Representative Signature Date	**For Office Use Only:** Verified By:_____ Signature:_____
Basis for which representative has the authority to act for the Patient, i.e. Parent/Guardian of a minor, Guardian/Conservator of incompetent Patient, Beneficiary or Representative of deceased Patient	D. Lic#:_____ SS#:_____ Other:_____

Patient Information/Label

Wythe County Community Hospital