



**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ MR \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security # : \_\_\_\_\_ Legal Representative: \_\_\_\_\_

- I, or the individual's legal representative, authorize the disclosure of the below individual's protected medical and/or mental health information. I understand this authorization is voluntary.
- The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- **I understand that this authorization includes medical records that may contain mental health, drug and alcohol, and HIV/AIDS information. I elect to not have the following health information disclosed to the entity listed on this authorization:**

- Mental health records
- Records pertaining to drug and/or alcohol abuse
- HIV, or AIDS-related information
- There are no restrictions on this request.

**← Please complete this section**

I understand that I may revoke this authorization at any time by giving written notice to Scott Memorial Hospital. Scott Memorial Hospital will honor my revocation except to the extent of actions taken prior to this request.

**Scott Memorial Hospital will disclose (send) my Protected Health Information to:** Specifically identify the person or organization, who you are authorizing to receive, to make use of, and/or to disclose the protected medical and/or mental health information described above:

(Name/Address) \_\_\_\_\_

**Information that may be requested or disclosed is as specified:**

- Discharge Summary
- Physical Examination
- Surgical Reports
- Consultation Reports
- Diagnostic Reports
- Other, *please describe:*

**Purpose information is being used/disclosed:**  Continuing Care  Legal Issue  Insurance  Treatment

Other: \_\_\_\_\_

**Expiration:** This authorization will expire (*complete one*):  90 days from signature below  
(NOTE: If nothing is checked, this authorization will expire in 120 days)  Specify Date \_\_\_\_\_

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Scott Memorial Hospital may receive, use, and/or disclose to the persons and/or organizations named in this form the protected health information described.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_