AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Authorization for: ⌈ Copies of Medical Record ⌈ Inspect or Review Medical Records

Patient Information	**Patient Name: _____MRN:_____** **(Last Name) (First Name)** **Date of Birth:_____ Phone:_____**		
Release To	**I authorize Monroe County Hospital to release records to:** **Person/Organization: _____** **Address:_____** **City/State/Zip: _____** **Phone: _____ Fax: _____**	**Purpose**	**For the following:** **___ Continuing Care** **___ Insurance** **___ Legal** **___ Personal Use** **___ Other: _____** **_____**
Information To Release	Treatment Dates: _____ ___Discharge Summary ___ ER Record ___ Operative Report ___ X-ray Film/CD ___ X-ray Report ___ Consultation ___ Other (Please Specify) _____ _____ **State/Federal Laws require specific authorization to release the following types of information: *(Initial all applicable)*** **___** Mental Health ___ HIV test results ___ Alcohol/Drug Abuse ___Sexually Transmitted Disease (STD)	**Fees**	Based on Alabama Code Section 12-21-6.1, Fees may be charged For medical record copies
Expiration	This authorization shall be in force and effect until _____but ***not*** greater than six months. If I fail to specify an expiration date, this authorization will expire six months from the date of my signature. ***I understand that I have the right to revoke this authorization, in writing, at any time, however, revocation will not have any effect on prior disclosures pursuant to this authorization.***		
Delivery Instructions	____Mail records directly to person or organization specified; ____ Patient or Representative to pick up. I authorize _____ to pick up my medical record copies . Relationship to patient _____.		
Signature (Picture ID Required)	Signature: _____(Patient or Legal Representative) Date: _____		
	Signature:_____(Personal Representative) Date: _____		