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: _____

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