AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION 4/11/03

PATIENT NAME (Current and Previous)_____

DOB:_____ **SSN**_____**Phone (H)**_____ **Phone (W)**_____

ADDRESS:_____

Provider **Name and Address:**_____
Who has the information? O Hospital
O Clinic _____
O Other
Ph:_____ FAX:_____

Requestor O Patient **Name and Address**_____
Who needs the information? O Hospital
O Clinic _____
O Other
Ph:_____ FAX:____ _____

Information Required

- O Consultation Reports
- O Discharge Summaries
- O EKG Reports
- O ER Reports
- O History & Physical
- O Immunization Record
- O Lab Data
- O Operative/Outpatient Reports
- O Clinic Visit Notes
- O Pathology Reports
- O X-Ray Films / X-Ray Reports
- O Other_____

Medical Condition/Injury And Time Period Dates and Description of Condition/Injury:_____
_____

Restrictions (optional) List Restrictions regarding information to be released:_____
All records pertaining to mental _____
Health, chemical dependence, _____
And/or AIDS-related illness will be released unless otherwise indicated here.

Purpose of Release

- O Continued Care
- O Education/Research
- O Moving Out of Town
- O Legal
- O Consult/ Second Opinion/ Personal
- O Insurance Claims Process or Work Comp
- O Selected New Physician
- O Other_____

REVOCATION: I understand that I may revoke this consent at any time and that the consent will automatically expire 12 months from the date of my signature.

I do not authorize further release to any third party. I understand that once information is released under this authorization, Parkview Medical Clinic and their employees and physician(s) cannot prevent the redisclosure of that information.

AUTHORIZATION: I authorize the above provider to release the information marked above to the recipient.

_____ _____
(Signature of Patient/Guardian) (Relationship to Patient if Signed by Guardian)

_____ _____
(Date of Patient's Signature) (Reason Patient Unable to Sign)

Records Copied:_____ By Whom_____
(Date)

Medical record copies will be: **Mailed**_____ **Picked Up**_____