

MR # _____

Acct. # _____



HIM Phone: (989)731-2224
Fax: (989) 731-2231

AUTHORIZATION FOR RELEASE OF INFORMATION
(Request by Patient or Patient's Representative)

I hereby authorize Otsego Memorial Hospital to disclose my individually identifiable health information as described below, including but not limited to information concerning communicable diseases such as venereal disease, TB, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency, psychological or social service records, laboratory test results, medical history, treatment, or any such related information. I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name **Date of Birth**

Address **City** **State** **ZIP**

Date of service (if known): _____

Description of information to be released (check all that apply):
____ Emergency Room/MedCare Clinic ____ Admission records (H&P) ____ Progress notes ____ Discharge Summary
____ Consultation reports ____ Physician orders ____ Operative records ____
X-ray reports ____ Nurses' notes ____ Laboratory reports ____ X-ray films ____ Billing records
____ Other (specify)

Description of the purpose of the use and/or disclosure (see examples): _____

The health information described herein shall be released to: __ Hospital; __ Physician; __ Insurance Company;
__ Attorney; __ Patient (self); __ Other (check appropriate category)

Name of Organization

I understand that this authorization will expire in 60 days from the date of signature.

I further understand that I may revoke this authorization at any time by notifying Otsego Memorial Hospital in writing

I also understand that the written revocation must be dated with a date that is later than the date on this authorization and signed. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that my continued or future treatment by or payment to Otsego Memorial Hospital is not conditioned upon my providing or signing this authorization. I understand that I have the right to inspect or copy the health information Otsego Memorial Hospital intends to use or disclose pursuant to this authorization, and I may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.

_____(initials) I have been provided with a copy of this authorization for my records.

Signature of Patient or Patient's Representative **Date**

Printed Name of Patient **Signature of witness**

_____ **Relationship to Patient** **OR** **Legal Authority (attach supporting documentation)**