

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Medical Record #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

- Inpatient                       Outpatient                       Emergency

**I AUTHORIZE THE MEDICAL RECORDS DEPARTMENT TO RELEASE THE FOLLOWING INFORMATION:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Summary or Abstract          | <input type="checkbox"/> Operative Report                             | <input type="checkbox"/> Nurses Notes         |
| <input type="checkbox"/> Entire Medical Record        | <input type="checkbox"/> Anesthesia Record                            | <input type="checkbox"/> Emergency Room Notes |
| <input type="checkbox"/> Discharge Notes              | <input type="checkbox"/> Pathology Report                             | <input type="checkbox"/> Medication Record    |
| <input type="checkbox"/> Admission History & Physical | <input type="checkbox"/> Diagnostic/X-Ray Reports                     | <input type="checkbox"/> Progress Notes       |
| <input type="checkbox"/> Consults                     | <input type="checkbox"/> Laboratory Results                           | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Physician's Orders           | <input type="checkbox"/> Psychotherapy Notes or mental health records |   |

Please send information to:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Purpose:

- At my request                       Other: \_\_\_\_\_

If your medical record contains any records obtained from other providers (Please check one):

- I prohibit their release:  
 I authorize and request their release [unless prohibited by the other provider(s)].

This Authorization is valid for up to **12 months from the date of signature**, unless a shorter period is listed below.

Expiration Date or Event: \_\_\_\_\_

I understand that I may refuse to sign this Authorization. If I do not complete this Authorization, it will not affect the use or disclosure of my protected health information for purposes of treatment, payment or eligible for benefits. I can change my mind at any time and revoke in writing my permission to allow my protected health information to be used or disclosed under this Authorization, except to the extent Holy Cross Hospital relied on this Authorization.

I understand that Holy Cross Hospital will not release my protected health information to others except as authorized by me or permitted by law. Once my protected health information is shared with a group or individual that is not required to follow federal privacy laws, Holy Cross Hospital cannot assure that the information will remain confidential.

\_\_\_\_\_  
 Signature of Patient or Representative                      Date                      Relationship to the Patient

**NOTE: There is a \$22.38 base fee and 0.73¢ per page fee for the processing of copies of medical records for third party requestors. For patient access there is a fee of 0.73¢ per page copied. There is no fee for sending copies of medical records to physicians or other health care providers.**