

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Sibley Memorial Hospital to disclose the following information from the Health records of:

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____ SSN: _____

Covering the period: From _____ to _____
(Date) (Date)

I authorize the hospital to release the following medical reports. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Please check desired information to be sent:

- | | | |
|---|---|---|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> EKG/EEG Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> ER Record |
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Abstract of Record (as listed above) | |

This information is to be disclosed to: _____

For the purpose of: _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or have copied the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

Sibley Memorial Hospital is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Date (Patient Signature) or _____
(Person Authorized to Consent)

(Witness Signature) (Relationship to Patient)