

**AUTHORIZATION FOR RELEASE
OF INFORMATION**

I, the undersigned patient or legal representative, hereby authorize **MIDSTATE MEDICAL CENTER** to use or disclose health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name: _____ **Birthdate:** ___/___/___ **Medical Record #** _____

<p>The information may be disclosed to and used by the following:</p> <p>NAME: _____</p> <p>ADDRESS: _____</p> <p>TELE #: (____) _____</p> <p>The purpose of this disclosure or use is for the following reason:</p> <p><input type="checkbox"/> Medical <input type="checkbox"/> Legal <input type="checkbox"/> Disability <input type="checkbox"/> Insurance</p> <p><input type="checkbox"/> At the request of the patient or legal representative</p> <p><input type="checkbox"/> Other (please specify) _____</p>	<p>The dates of service and the type(s) of information to be used or disclosed is as follows:</p> <p>Date(s) of Treatment: _____</p> <p><input type="checkbox"/> History & Physical <input type="checkbox"/> Laboratory Results</p> <p><input type="checkbox"/> Discharge Summary <input type="checkbox"/> Pathology Reports</p> <p><input type="checkbox"/> Operative Reports <input type="checkbox"/> Cardiology Reports</p> <p><input type="checkbox"/> Consultations <input type="checkbox"/> Neurology Reports</p> <p><input type="checkbox"/> Progress Notes <input type="checkbox"/> Radiology Reports</p> <p><input type="checkbox"/> Ambulatory Record <input type="checkbox"/> Radiology Films (Radiology Dept)</p> <p><input type="checkbox"/> ED Record <input type="checkbox"/> Radiation Treatment Record</p> <p><input type="checkbox"/> Behavioral Health Record</p> <p><input type="checkbox"/> Billing (directed to Patient Accounts at 1-888-271-8662)</p> <p><input type="checkbox"/> Other (please specify) _____</p>
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This authorization will be valid for a period of one year from the date below. I understand that I may cancel this authorization at any time by notifying the Health Information Management Department in writing, but if I do it will not have any effect on actions that the hospital took before it received the cancellation.

I understand that my treatment or continued treatment by MidState Medical Center is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that I may inspect or copy the information to be used or disclosed.

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian. Minors receiving drug abuse treatment or treatment of venereal disease may sign their own authorization.

I understand that MidState Medical Center may receive compensation for copy and processing fees related to the use/disclosure of my health information under this authorization.

Signature of Patient or Legal Representative

Date

Witness

If signed by the Legal Representative, indicate your relationship to the patient below:

Parent Guardian Conservator Executor of Estate Power of Attorney Other _____