MEMORIAL HEALTH CARE SYSTEMS
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FORM

PATIENT NAME_____ **D.O.B.**_____

ADDRESS_____ **PHONE #**_____ **ACCT. #**_____

I hereby authorize MHCS (Family Medical Centers, Memorial Hospital, Pharmacy) to use and/or disclose my health information as follows:

DISCLOSE TO:_____
Recipient Name Address Phone Number

PURPOSE(S) OF DISCLOSURE:_____

☐ Check this box if disclosure is at the request of the individual.

☐ If the purpose for the disclosure is marketing, check this box only if MHCS *will* receive direct or indirect remuneration from a third party.

INFORMATION TO BE DISCLOSED:

☐ Complete record	☐ Emergency room record
☐ History and physical examination	☐ Discharge report
☐ Progress notes	☐ After care plan
☐ Lab reports	☐ Financial record
☐ X-ray reports	☐ Other
☐ Consultation report	

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)
☐ Mental health
☐ HIV/AIDS related information (including test results)

DATES OF SERVICE OR TIME PERIOD OF RECORDS TO BE DISCLOSED:_____
(State time period or "all")

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at MHCS.

2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.

3. This authorization is effective for _____ months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to _____. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.

4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Signature of patient or patient's personal representative Date

_____
Relationship to patient if signed by personal representative

_____ _____
Witness Date