MEDICAL RECORD # ________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, hereby authorize Butler County Medical Center to release information from my (or give relationship) ______________________ medical or financial record. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism and/or psychiatric/psychological conditions.

PATIENT INFORMATION (Please Print)

____

Last Name | First | Middle | Maiden (If applicable) | Male/Female

____

Address | City | State | Zip

____

Date of Birth | Social Security Number | Phone Number

The following information (but not limited to) may be released or reviewed:

Records requested:

- ❑ Medical History
- ❑ Physical
- ❑ Consultation Notes
- ❑ Discharge summaries
- ❑ Order and Progress Notes
- ❑ Medication Reconciliation Record
- ❑ Health Insurance (Medicare/Medicaid)
- ❑ Laboratory Results
- ❑ Operative Records
- ❑ Inpatient Records
- ❑ X-ray Reports
- ❑ Other_________________

____

Dates of Treatment/Particular Illness/Admission:

____

Name and title of the person the above information is to be released to

____

Street Address

____

City, State and Zip

Records may be:
- ❑ Mailed
- ❑ Picked up

____
(Specify if other than parent/guardian
- ❑ Review only

Purpose for release of information:
- ❑ Medical Care
- ❑ Attorney/Legal
- ❑ Personal
- ❑ Insurance
- ❑ Disability/SSI

This statement must be signed and dated and may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire (60) days after the date below, or sooner by my choice, in which case this consent will expire on ________________________________.

I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

There is no cost for records if released for continuation of care to another Medical Facility or Physician. Attorney's, and for personal use will be billed accordingly. Patient must sign the authorization if he/she is an emancipated minor.

Signature ____ Relationship ________________________ Date __________________
(Legal Guardian)