Cogdell
MEMORIAL HOSPITAL

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Medical Record Number: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Date of Birth: _____

I authorize the hospital to use and/or disclose my health information as follows:

Disclose To:

Recipient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone 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 the hospital will receive direct or indirect remuneration from a third party.

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Information to be Disclosed:

- ❑ History and Physical Examination
- ❑ X-Ray Reports
- ❑ Discharge Report
- ❑ Complete Record
- ❑ Progress Notes
- ❑ Consultation Report
- ❑ After Care Plan
- ❑ Financial Record
- ❑ Lab Reports
- ❑ Emergency Room Record

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: _____

I understand and acknowledge that:

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

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 six (6) months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to [need information]. 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: _____

Relationship to Patient if Signed by Personal Representative: _____

Date: _____