For Office Use Only:
Verified: Yes/No
By: _______ D.Lic#: ___________
SS#: ______________
Signature: Yes/No

RELEASE OF INFORMATION

☐ AUTHORIZATION ☐ REQUISITION

SECTION A: (This section to be completed by the patient.)

Patient's Name: ______________________________________ Medical Record#/ID#: ______________
Date of Birth: ___________________________

List the specific information that is authorized for this disclosure:
Dates of Service/Encounter to be release: _________________________

☐ Anesthesia	☐ Consultation	☐ Discharge Sum	☐ EKG's	☐ Emergency	☐ Facesheet
☐ History/Phys	☐ Imaging Rpts	☐ Laboratory	☐ Medication	☐ Nursing	☐ Surgery/Proc
☐ Orders	☐ Outpatient	☐ Pathology	☐ Progress Nts	☐ Billing Rec	☐ UB 92
☐ Itemized Bill	☐ Acc of Discl	☐ Entire Record	☐ Other	☐ _________	☐ ___________

Release Information To:
Name: _____________________________________
Address: ___________________________________
City, State, Zip: _____________________________

Describe the purpose/reason for this request.
____
____

SECTION B: (Patient must read and complete information in this section.)

I hereby authorize Bolivar Medical Center to use/disclose my individually identifiable health information the manner described within this authorization. I understand that this authorization is voluntary and that if the person or entity authorized by this document is not a health plan or healthcare provider that my information may no longer be protected from further disclosure by state or federal law.

Do you want the Hospital to release your psychotherapy notes (if any) to the person or facility you have listed above?
☐ Yes or ☐ No

- I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization or that refusal to sign this authorization will not affect my treatment
- I understand that information used or disclosed to an entity other than a health plan or healthcare provider may be subject to re-disclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 CFR160 and 164.
- I understand that this authorization will expire on _____/______/_______. (If no date is written, this authorization will expire one year from the date on which it is received by the hospital.)
- I understand that I may revoke this authorization at any time by notifying Bolivar Medical Center in writing, except to the extent that has already taken in reliance of the previous authorization period.
- I understand that if my records contain sensitive information that I may need to have by physician authorize the use of disclosure of it.
- I understand that I have the right to see this information described on this form if I ask to see it, and I understand that I may request a copy of this form after I sign.

____ ____________________
Signature of Patient or Patient's Representative Date

If not signed by patient, please indicate relationship: ☐ Parent or guardian of minor patient ☐ Guardian or conservator of incompetent patient ☐ Beneficiary or representative of deceased patient

****Please provide Power of Attorney, Picture ID (Driver's License)