Bolivar Medical Center

BOLIVAR MEDICAL CENTER

AUTHORIZATION / REQUISTION (circle one)
FOR RELEASE OF INFORMATION

For Office Use Only:
Verified: Yes / No
By:_____
Driver Lic.#:_____
SS #: _____
Recipient Signature: Yes / No

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

Patient's Name: _____ Medical Record #/ID number: _____
Date of Birth:_____

List the specific information that is authorized for disclosure:

Dates of Service/Encounter to be released: _____

Please check options listed below:

❑ Anesthesia	❑ Consultation	❑ Discharge Sum.	❑ EKG's	❑ Emergency	❑ Facesheet
❑ History/Phys	❑ Imaging Rpts	❑ Laboratory	❑ Medication	❑ Nursing	❑ Surgery/Proc
❑ Orders	❑ Outpatient	❑ Pathology	❑ Progress Notes	❑ Billing Rec	❑ Birth Verification
❑ Itemized Bill	❑ Acct. of Dis.	❑ Entire Record	❑ Other	❑ _____	❑ _____

Release Information To:

Please Return To:
BOLIVAR MEDICAL CENTER
Attn: Release of Information
901 Hwy 8 East
Cleveland, MS 38732
Phone: 662-846-2575 / Fax: 662-846-2476

Name of Recipient Receiving Medical Records _____

Mailing Address _____ **City/State** _____ **Zip Code** _____

Phone Number _____ **Fax Number** _____

Email Address **(Optional)** _____

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 in 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 health-care 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?
Circle One: Yes / No

- I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my behalf 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 health care 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 I may revoke this authorization at any time by notifying Bolivar Medical Center Health Information Management Department in writing, except to the extent that has already been taken in reliance of the previous authorization period.
- I understand that records contain sensitive information that I may need to have my physician authorize the use of disclosure of it.
- I understand that I have the right to see the 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 it.
- 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 Bolivar Medical Center.)

X _____ **X** _____

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 Healthcare Power of Attorney / Driver's License***

The Medical Record Department is not responsible for completing this form. All entries must be completed by the requestor to receive medical records.